NHS
Sheffield Teaching Hospitals
NHS Foundation Trust

Annual Report and Accounts
2020-21

PROUD TO MAKE A DIFFERENCE
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

Sheffield Teaching Hospitals NHS Foundation Trust

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Contents

Chair's Introduction

I am pleased to be able to write this introduction as the new Chair of Sheffield Teaching Hospitals NHS Foundation Trust. This year has seen the whole world turned upside down and life as we knew it has been very different for everyone. For the NHS and our Trust, we have been faced with challenges we could never have imagined due to Covid-19. The incredible resolve, dedication and innovation of our 18,500 army of heroes working across our hospitals and community services has enabled us to meet that challenge.

In the past 12 months we have cared for over 5,000 people with the awful virus whilst at the same time continuing to provide urgent and emergency care for hundreds of thousands of other patients. Sadly there have been more than 1,000 people who have lost their lives in Sheffield as a result of Covid-19 and every one of those deaths is a devastating loss to their loved ones.

Normally this Annual Report would describe our performance in many areas against national and local standards but this year so much of our normal way of delivering care has had to change or in some cases be paused in order to keep our most vulnerable patients safe from the virus. So this report includes performance information which should be read in the context of the pandemic and our colleagues having to manage three significant peaks of Covid-19 which necessitated much of our ward capacity being used for those patients.

Despite the constraints the virus has placed upon us, colleagues across the organisation have taken every opportunity to look at how we can continue to provide care. The level of innovation we have seen has been staggering especially in such a short period of time. We were able to continue with a significant number of outpatient appointments by embracing digital technology, which meant we could hold online appointments where appropriate and prevent cancellations. Feedback from our patients has been extremely positive, so this is something we will look to continue where appropriate as we move forward.

Another service which has been embraced by patients is drive-through phlebotomy which we set up at Sheffield Arena. Instead of patients having to come into hospital for their routine blood tests, they were able to use a drive-through service. We have now moved this to the Northern General Hospital site where it continues to be really popular. We continued to use the Arena as part of the NHS Vaccination Programme which we have delivered in partnership with our CCG, secondary care and primary care colleagues.

Ensuring the continuation of emergency and urgent care has been a priority, and again teams have developed and expanded new ways of providing care to limit the time patients had to stay in hospital. The new Same Day Emergency Care (SDEC) unit has enabled more patients to go home the same day, and the team also

introduced a new process that enables patients to be treated more quickly by allowing the Yorkshire Ambulance Service to bypass the Emergency Department, bringing patients straight to the SDEC service. Pre-operative assessment colleagues also re-designed their processes and created a virtual system. This enabled the team to increase the number of assessments taking place and simplified the process for patients.

Our community teams were relentless in adapting their practices so that frail and vulnerable people living at home continued to receive the care they needed, and that those at end of life had the support they needed even in a pandemic.

These are just a few of the examples of how colleagues have gone above and beyond to keep services going safely even during a pandemic.

Caring for patients has been a priority but so has caring for our staff. Without them we would not have got through this year and it has been gruelling on every single person, not just those in direct patient care. We have ensured they had the protective equipment they needed, increased the wellbeing support on offer, including setting up 40 Calm Rooms across our Trust thanks to Sheffield Hospitals Charity, and expanded the 24 hour mental health support service. We have plans in place to continue to increase both physical and mental wellbeing support into 2021, including the creation of a secret garden for staff and patients to enjoy moments of tranquillity. During the year we continued to progress the other ambitions in our People Strategy and I am particularly pleased that we have published a new Equality, Diversity and Inclusion Strategy which is being supported by our flourishing staff networks. You can read more about this on page 50.

Our partners, new and old have been invaluable in helping us to manage the different aspects of the pandemic, including Sheffield Arena which provided storage for our stocks of PPE to ensure we did not run out and staff were protected. Business and school partners manufactured PPE for us to use, and of course much of the research which has contributed to understanding more about the virus and how we treat it, has come from our partnership with the City's universities and those further afield. You can read more about the research work we have been involved in on page 12.

The support we have had from our local communities has also been overwhelming and it is times like these that foster new relationships which we intend to build upon as we start our recovery and reset of services. This work has already started and will remain our focus as we continue into 2021/22. We have redesigned many of our facilities to enable us to continue to practise social distancing and maintain robust infection control measures, whilst resuming as many appointments and procedures as is safe to do so. It will take us time to catch up completely, but we are confident we can get back to our previous excellent position in terms of waiting times and lists. As well as looking to do as much as we can internally, we also want to play our part

in re-building the communities we serve especially given the inequalities Covid-19 has further exposed across many parts of our City and wider region. Our responsibilities as a major employer and anchor institution have never been more important, and we are keen to reflect these aspirations in a refreshed corporate strategy during 2021/22. As a partner in the Sheffield Accountable Care Partnership and South Yorkshire and Bassetlaw Integrated Care System we have the opportunity to make a real difference moving forward, and the past year has already shown the power of what working collectively can achieve.

Finally, I must mention the outstanding contribution of our volunteers, who have taken on new challenges without question, including supporting the vaccination programme and helping to keep loved ones in touch when visiting in person was not a possibility. I would also like to acknowledge the unfaltering support of our Governors, Charities, fellow Board members and my predecessor Tony Pedder who has guided the Trust for almost 10 years before retiring this year. I thank them all for their dedication and support during this unprecedented year for the NHS and for our own organisation.

Annette Laban
Chair

Performance Report

Overview of Performance

This section provides an overview of the Trust, its purpose, key risks to the achievement of its objectives and how it has performed during the year.

Annual Performance Statement from the Chief Executive

There is no doubt that this has been an extraordinary year which has touched every part of the NHS and our Trust is no exception. With this in mind my report is very different to previous years and reflects the significance of providing care for Covid-19 patients during the pandemic. This has impacted on the services we provide and the progression of some corporate objectives which were outlined in the previous year's Annual Report. This year the performance data contained within this document should also be read in the context of the impact of Covid-19.

In the last 12 months, we have cared for over 5,000 patients with Covid-19. This was a phenomenal achievement in terms of treating so many people with a virus that we had not even heard of just over 12 months ago. As well as supporting those patients who had the virus our teams never stopped providing emergency or urgent care to other patients where it was appropriate and safe to do so. This included those with illnesses and conditions like strokes, heart attacks and the vast majority of cancer care. Our maternity services carried on doing what they do best and delivered over 6,000 babies during the year, and our neonatal teams have made sure our tiniest babies continued to have the lifesaving care they needed. Our community teams turned their way of working on its head to continue to provide as much care as possible to some of the most vulnerable in our communities. This was at a time when isolation and loneliness were also significant issues for those patients.

We had to limit visiting during most of the year which we know was so hard for both patients and their loved ones, but it was necessary to limit the spread of the virus. We put considerable effort into enabling families to stay connected, including a Keeping in Touch service for nominated relatives or friends to be able to email or phone for an update on their loved one. This was also available for critical care patients. We put iPads and other devices on all wards to ensure patients could speak to and see their relatives. Our critical care team even made a short video to show relatives where their loved one was being cared for and the team caring for them.

Whilst our efforts during the year in our hospitals was very much focussed on providing care for patients with the virus and on urgent / emergency care, we were also concerned that a significant number of our other patients had to have their care

paused. This was either because of the risks to them from Covid-19 or the restrictions placed on all hospitals as part of the Covid-19 NHS response. Where possible we quickly changed how we delivered care so that as many patients as possible could still have their outpatient appointment or treatment safely where appropriate.

Thanks to the hard work of our teams in our hospitals and community health services, we continued to carry out thousands of online and telephone consultations so that patients did not have to leave their homes. We also developed new services like drive-through blood testing at the Sheffield Arena, and our diagnostic teams reconfigured our scanning and X-ray departments to safely accommodate tests which were urgent. Where care could not be provided, we quickly put in processes to monitor and clinically review those patients whose care was paused.

Re-designing care pathways and services has been no mean feat in an organisation of our size, which usually admits around 15,000 patients every month for planned care, as well as providing emergency care for another 12,000 patients. Our teams took up that challenge without question and thanks to their fantastic work and innovation a significant amount of patient care has recommenced.

I am proud to say that in the later part of 2020/21 the vast majority of our services were back up and running and our performance in terms of 18 week waits and cancer standards was above the national average, whilst recognising it still fell short of the national standards in place pre-Covid-19.

In addition to the re-design of services, two other factors were pivotal to being able to manage both Covid-19 and non-Covid-19 patients simultaneously. One was the incredible work our laboratory services undertook to develop a staff and patient Covid-19 testing service in advance of any national system. This meant our staff could quickly access a test if they had symptoms, and either isolate to prevent further transmission if they were positive, or return to work safely knowing they had a negative result. This had a huge impact on our ability to plan the workforce to respond to demand, and was fundamental to protecting our staff as well as patients.

We also introduced Covid-19 testing for patients being admitted through our Accident and Emergency Department or our Assessment Unit. As the year progressed, our laboratories were amazingly fleet of foot in adapting to the changing national guidance on testing staff and patients, as well as supporting many of our partner organisations and care homes that did not have access to testing. During the course of the year our laboratories have processed a staggering 307,944 test samples. The team have also contributed to the Department of Health and Social Care's expert advisory group on the virus NERVTAG due to their expertise and experience.

We also supported care homes in the city with advice and personal protective equipment (PPE) where they needed it. Due to Covid-19 we also changed our

discharge processes so that every patient who left our hospitals to go to a care home was tested prior to discharge. Information on their status was discussed with the care home to ensure they were happy to admit the patient. We also checked that the home had appropriate measures in place to accept the patient safely.

There is no doubt that the work of our supplies department in terms of getting ahead of the curve in procuring PPE was fundamental to how we could continue to deliver care safely. During the year we have used an incredible 56 million items of PPE. Partnerships were critical to our efforts including: work with the Sheffield Arena to store the PPE we needed; our universities, schools and businesses who stepped up to help us by manufacturing some items; and, the establishment of a multi-disciplinary Clinical Expert Group. As a result of these and more, I am confident that we managed to avoid some of the PPE problems seen elsewhere in the NHS. Our procurement team has done a brilliant job throughout the outbreak, so much so that we were one of 14 trusts the Government asked to advise on national efforts to source PPE.

We have not been able to switch everything back on straight away, either because of the ongoing risks to some groups of patients, or because there are other factors to consider. For example, we now have 50 per cent less space to use in our clinics, waiting rooms and departments due to the requirements for social distancing to keep everyone safe. We also need to take a completely different approach to how we schedule appointments since we can't have large numbers of people waiting together in rooms anymore.

Catching up on paused care will be our top priority as we move into 2021/22, as well as managing the usual challenges of winter and a potential flu outbreak. We will also need to continue to be vigilant and ready to escalate plans for further outbreaks of Covid-19.

Sadly, the legacy of Covid-19 will be widened and deepened further because many people who have had the virus have been left with debilitating health issues that will require longer term support. This has been described as Long Covid-19. We have been a national leader in this field by working with primary care and other colleagues across the city to set up a multi-disciplinary rehabilitation and support service. The development of the service has been designed with people who are experiencing Long Covid-19.

We also continue to lead the NHS Covid-19 vaccination programme for South Yorkshire and Bassetlaw working with our partner NHS trusts and primary care colleagues. What has been achieved to date is staggering and an example of the NHS working at its very best. In addition to 17 Primary Care vaccination sites, STH established a large scale vaccination centre at Sheffield Arena at the end of April 2021. This has allowed more than one million vaccines to been given to eligible residents across South Yorkshire and Bassetlaw. Our staff, volunteers and partners

have been amazing in their response for which we are extremely grateful and proud. It is clear that the success of the vaccine programme, especially the prioritisation of those groups most at risk has been absolutely pivotal in the sharp reduction in hospitalisations and deaths we have seen since the start of 2021.

Whilst a lot of our attention has been consumed by Covid-19 I would like to mention some other developments, investments and performance which were also achieved in 2020/21; a year when innovation and learning became our mantra.

Prior to the pandemic we were already focussed on how we can reduce the time patients need to stay in hospital, or indeed if we can prevent admission at all if it is in the best interests of the patient. An example of this is the new Same Day Emergency Care (SDEC) service which has been launched. This enables patients to be treated more quickly by allowing the Yorkshire Ambulance Service to bypass the Accident and Emergency Department, bringing patients straight to the SDEC service. Over the past 12 months the service has treated 2,011 patients and patient feedback has been very positive.

Colleagues in our Musculoskeletal teams have piloted carrying out hip replacements as a day case procedure, rather than the traditional three to four day hospital admission. Initial feedback has been extremely positive and learning from the approach is being shared more widely with other services.

Despite the constraints of Covid-19 our teams continued to push the boundaries of medical science. One example of this was a procedure to repair a rare, life-threatening weakening in the wall of the largest artery in the body, in an area called the aortic arch. Our Interventional Radiologists used a minimally invasive procedure, inserting an expandable stent graft into the intricate structures of the aortic arch. Because of the patient's age and poor levels of fitness, she would not have been able to withstand conventional open-heart surgery. The procedure has been done just four times elsewhere in the UK.

2020/21 was a landmark for another reason within our Trust, as we celebrated 50 years of Weston Park Cancer Centre where so many advances in cancer care and research have originated over the years. Continuing that legacy, we have used this past year to progress a business case for a multi-million-pound re-development of the Centre, including a new research facility supported by our partner The University of Sheffield. This was to be a key strategic objective within our new corporate strategy which had to be paused this year due to the limited capacity of teams and opportunities to do meaningful engagement with our partners and communities.

We will resume this work in 2021 and use the learning from the past 12 months to shape our future direction of travel. Part of this work will include a new sustainability strategy as we are keen to build on the foundations of what we started pre-Covid19. We are very aware that our size means we have a significant impact on our environment and the prosperity of the City and wider region. We take these

responsibilities very seriously and during the year we began to look at how we could accelerate the work already undertaken on sustainability, job creation, widening education opportunities and improving population health.

With respect to sustainability, over two million patient contacts a year means it is important we consider how we deliver care and where possible reduce reliance on transport or multiple visits. We have started work on a piece of work to look at how we work now and how we can adapt. Our response to the Covid-19 outbreak will further inform this, particularly for outpatient appointments which have switched rapidly to video and telephone consultations due to the rules around social distancing. Our new strategy for sustainability will widen our approach on this agenda during 2021/22.

Caring for our staff

Of course, all of this is not possible if we don't look after the people providing the care. We have invested a lot of time listening to what our staff needed during the past year and trying to do all that we could to keep them well physically and mentally during such gruelling times. We extended our 24-hour mental health counselling service, encouraged people to take their leave, developed toolkits for managers to be able to give additional support to teams, and with support from Sheffield Hospitals Charity we set up a number of Calm Rooms. These are peaceful places where staff can go to recharge, have something to eat and drink and just take a few moments away from what is happening. As well as using digital technology to provide care for patients we also encouraged its use for team working especially given a significant proportion of colleagues were remote-working. However, I think the biggest thing we did was focus on being kind to each other; encouraging a culture of recognition and understanding of the situations people were in, professionally and personally, and taking time to say thank you.

You can read more about our progress in implementing our People Strategy within the Staff Report section. One area I would particularly like to highlight and which has proven to be even more important during the past year is our work on equality, diversity, and inclusion. Early in the pandemic, evidence emerged that some colleagues, including those from an ethnic minority, those with underlying health conditions and older staff may be more affected by Covid-19. In response we put in place additional health assessments for staff who are potentially more at risk from complications of Covid-19 and worked with our unions and staff networks to raise awareness of the importance of health assessments and vaccination.

We very quickly put support in place for colleagues who were shielding, and ensured we had safe working areas for staff, with clear guidance on what they should expect. We also provided all staff working on site with lateral flow test kits to be performed twice weekly. A drive-through staff PCR test facility was set up at the Northern

General Hospital for any member of staff worried they may have the virus and their family members.

Despite the unusual and exceptionally busy time we have had this year, our staff survey results were very encouraging, and we saw another increase in the percentage of staff who would recommend the Trust as a place to work and receive care. We are certainly not complacent though, and will be scrutinising the results in detail to develop action plans which address areas where we can do even better. You can read more about this on page 48.

Financial performance and investment in facilities

We achieved a surplus of £13.5 million but that is in the context of an unusual year where much of our planned activity was paused. Further information can be found on page 24.

Despite the pandemic, we continued to invest in our facilities where it was safe to do so and in total, we have invested over £44.4 million in 2020/21. We continued to progress the overhaul of our theatres at the Royal Hallamshire Hospital and the planned next phase of modernising the main patient and visitor lifts too.

Two more wards were refurbished at the Royal Hallamshire Hospital along with Vickers 4 at the Northern General Hospital. We purchased the Longley Lane site adjacent to the Northern General Hospital, and we will use this for ongoing strategic development of services.

We installed another radiotherapy linear accelerator at Weston Park Cancer Centre, this brings the number to eight, one of the highest of any radiotherapy department in the country. Over the course of its lifetime, the machine will provide 100,000 complex treatments to around 6,500 patients undergoing cancer treatment.

Throughout the year we continued to work with our PFI partners to rectify issues identified with the Hadfield Building at the Northern General Hospital site. We expect to re-open the facility subject to approvals in 2021.

We continued to invest in IT systems to enhance clinical safety, efficiency, and patient experience. One of the most significant investments we have planned is a new Electronic Patient Record System. Work to complete the business case and begin procurement began during the year and will continue into 2021.

Partnership working

If there is a positive to come out of this year, it has to be the way partners across public and private sector organisations have come together for a common goal. The support we have had to overcome, what at times, seemed insurmountable challenges has been remarkable and many of the usual barriers which have prevented more collaborative working in the past have been put aside. We have

strengthened existing partnerships and made new ones. Working within the Sheffield Accountable Care Partnership and South Yorkshire and Bassetlaw Integrated Care System has enabled us to share learning and plan together how we managed the response to Covid-19 for our region. Strong relationships with the City's Universities and business community have given us an opportunity to consider how together we can tackle the wider implications of the pandemic's impact on our region. A vision document was submitted to Government during the year outlining how this would be approached, and we are excited to take this forward over the next few years.

Delivering excellent research

Since the start of the pandemic the Trust has been taking part in a number of research studies to develop understanding of Covid-19. This will help progress the development of possible future treatments for Covid-19 and ways of diagnosing and preventing the virus.

As one of the most research active trusts in England, we have played a leading role in major flagship Covid-19 trials. We recruited the second highest number of patients in the country to the Oxford-AstraZeneca vaccine trial, and recruited many patients to the nationwide RECOVERY trial, the first to show that a drug (dexamethasone) could improve survival in hospitalised Covid-19 patients, back in March 2020. This trial continues to confirm and reject a number of possible treatments and provide vital evidence for our clinical teams.

The Trust is also one of only 17 sites across the UK, and the only one in the Yorkshire and Humber region, to test the safety and efficacy of a two-dose Covid-19 vaccine developed by the Janssen Pharmaceutical Companies of Johnson & Johnson.

Another landmark Covid-19 study involving our researchers and clinicians was the government-funded Remap-Cap trial. This was the second study in the world to demonstrate the availability of life-saving treatments for hospitalised Covid-19 patients.

As well as treatment trials and vaccine trials, we have played a leading role in Public Health England's SIREN study, which is looking at the real-world effect of Covid-19 infection and natural immunity in NHS workers. The Trust is currently one of the top recruiting sites in the region for this study.

Researchers have also gathered data from over 300 participants in a global initiative seeking to answer questions about why some people get more severe illness, what the best way is to treat the disease and how long people remain infectious for.

To date the Trust has supported over 40 Covid-19 studies, including 20 given urgent public health status by the Chief Medical Office and the Department of Health and

Social Care. We also set up a sequencing service with the University of Sheffield which has contributed to the COG-UK datasets identifying SARS-CoV-2 introduction events into the UK, identification of more transmissible strains, surveillance of new emerging variants, plus staff and hospital transmission data. We have been recognised nationally as being one of the leading clinical virology translational labs for sequencing research.

The Trust has continued to successfully win funding for other major grant awards during the pandemic, with fertility experts given £1.8 million from the National Institute for Health Research to lead a study evaluating if pregnancy success rates are improved by removing small fibroids and endometrial polyps in the womb. In partnership with the University of Sheffield and Crohn's and Colitis UK, Professor Alan Lobo, Consultant Gastroenterologist has also secured £450,000 to study what matters to patients who live with inflammatory bowel disease.

Professor John Snowden, Consultant Haematologist, and the Director of the Bone Marrow Transplantation Programme in Sheffield, was elected as President of the British Society of Blood and Marrow Transplantation and Cellular Therapy. In addition, Dr Josh Wright, Consultant Haematologist has become Vice President of the British Society of Haematology. Both roles will enable them to use their significant expertise to improve care for patients here in the Trust and nationwide.

The Gastrointestinal Unit was also granted Centre of Excellence status by the World Endoscopy Organisation. The award is currently held by only 21 other centres in the world, and only one other UK centre holds the international accolade.

Finally, the NIHR Devices for Dignity MedTech Co-operative was awarded a prestigious £6 million grant to develop technology for individuals requiring muscular support. The five-year research project is being funded by a prestigious Engineering and Physical Sciences Research Council (EPSRC) through its Transformative Healthcare Technologies for 2050 programme.

Conclusion

After an unprecedented year which has left no corner of our organisation untouched, and our services and care needed more than ever before, I want to pay tribute to everyone who has contributed to the incredible response to the situation we have found ourselves in. Thank you to everyone in the City who has offered us incredible support in one form or another, our patients and their families who have been so understanding of the position we have been forced to manage.

Thanks also to our partners across the NHS, Council, Social Care, Public Health England, Universities, local businesses, and all the key workers who have worked alongside us to deliver what was needed to manage the pandemic. Our charities have been relentless in their support and our Board and Governors have provided

the stability, discussion and challenge which is so important during more turbulent times.

Above all I am so very proud of all our staff and volunteers for their tremendous achievements, self-sacrifice and dedication. I am in no doubt this has been the basis for this organisation's success, for the quality of care provided to patients, and the success of the biggest vaccination programme many of us will see in our lifetime.

It has been a steep learning curve, but one which as a 18,500 strong team we have embraced without question. There is not one person who has not played their part and I am in no doubt that this next challenge to reset our services and do the right thing for all our patients will be met with the same determination, creativity and pride, as has been evident since the first cases of Covid-19 arrived at our doors.

Kirsten Major
Chief Executive
11 June 2021

History, purpose and principal activities of the Trust

Sheffield Teaching Hospitals NHS Foundation Trust is one of the UK's busiest and most successful NHS foundation trusts. Above all, patients lie at the heart of everything we do and we have a history of delivering high quality care, clinical excellence and innovation in medical research.

Formed in 2001, we are a high performing organisation providing personalised, acute, elective, community and specialist healthcare services of a high standard for over two million patients each year. We achieved Foundation Trust status on 1 July 2004.

We are one of the largest integrated NHS trusts in England. During the past year we have seen and treated over 980 thousand outpatients, over 686 thousand nurse contacts with community patients, over 98 thousand inpatients, over 89 thousand day case patients and over 121 thousand attendances to our Accident and Emergency Department. This year we have also cared for approximately 5,000 patients admitted with Covid-19.

Our staff provide a full range of local hospital and community services for adults in Sheffield, as well as specialist care for patients from further afield including cancer, spinal cord injuries, renal and cardiothoracic services. In addition to community health services, the Trust comprises five of Yorkshire's best known teaching hospitals.

The Northern General Hospital is the home of the City's Accident and Emergency Department which is also one of the three Major Trauma Centres for the Yorkshire and Humber region. A number of specialist medical and surgical services are also located at the Northern General Hospital including cardiac, orthopaedics, burns, plastic surgery, spinal injuries and renal, to name a few. A state-of-the-art laboratories complex provides leading-edge diagnostic services, which have been at the forefront of our response to Covid-19.

The Royal Hallamshire Hospital has a dedicated Neurosciences Department including an Intensive Care Unit for patients with head injuries, neurological conditions such as stroke and for patients who have undergone neurosurgery. It also has a large Tropical Medicine and Infectious Disease Unit, a specialist Haematology Centre and other medical and surgical services.

Sheffield Teaching Hospitals is home to the largest dental school in the region, a women's hospital with a specialist Neonatal Intensive Care Unit and a Fertility Unit. The Weston Park Cancer Centre is also part of our Trust.

The Trust also provides community health services to deliver care closer to home for patients and prevent admissions to hospital wherever possible.

We aim to reflect the diversity of local communities and have developed strong partnerships with local people, patients, and neighbouring NHS organisations, local authorities, charitable bodies and GPs. We are one of the region's largest employers and we take our responsibility to be a good corporate citizen very seriously.

We have a proud history of pioneering medical advances that have now become established NHS treatments, and undertaking high quality research that provides the NHS with the evidence it needs to introduce new treatments and care. Together with our partners at The University of Sheffield and Sheffield Hallam University we are leading the way on the development of world class clinical research in a wide range of disease areas, including cancer, progressive diseases such as dementia, stroke and multiple sclerosis, as well as heart disease and many other lesser known conditions.

Overview of the Trust's Strategy

Our 'Making a Difference' corporate strategy was originally developed in 2012 and then refreshed in 2017. It has enabled the Trust to be successful in providing high quality clinical care to our patients, being financially sound and remaining at the forefront of research and innovation throughout this period.

Our Vision

Our vision is to be recognised as the best provider of healthcare, clinical research and education in the UK and a strong contributor to the aspiration of Sheffield to be a vibrant and healthy city region.

Our Mission

We are here to improve health and wellbeing, to support people to keep mentally and physically well, to get better when they are ill and when they cannot fully recover, to stay as well as they can to the end of their lives. We aim to work at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. We touch lives at times of basic human need, when our care and compassion are what matter most to people.

Our Aims

- Deliver the best clinical outcomes
- Provide patient centred services
- Employ caring and cared for staff
- Spend public money wisely
- Deliver excellent research, education and innovation

Our Values

- Patient first - Ensure that the people we serve are at the heart of all we do
- Respectful - Be kind, respectful to everyone and value diversity
- Ownership - Celebrate our successes, learn continuously and ensure we improve
- Unity - Work in partnership and value the roles of others
- Deliver - Be efficient, effective and accountable for our actions

The rising challenges associated with maintaining the highest standards of healthcare delivery, responding to new government policy and change initiatives within the organisation prompted us to revisit the strategy in 2017. After a period of consultation with staff, patients, our Members and partners we refreshed the strategy, albeit it was felt that the Mission, Vision and Aims were still strong and applicable.

The current 'Making a Difference' strategy was due to expire in 2020 and we began the process of developing a new corporate strategy in the later part of the financial year. Following further discussion, the Board of Directors concluded that it would be premature to develop a longer term strategy in the face of the considerable uncertainty created by Covid-19.

As a result, it was agreed the annual corporate objectives would effectively act as the organisation's corporate strategy during this period of unprecedented change and uncertainty. We, therefore, moved the process to enable us to consider how the pandemic will impact our services and objectives in the future into 2021 and to allow for meaningful staff, patient, public and partner engagement.

Trends and factors likely to affect the Trust's future development, performance and position

In the context of delivering the Trust's strategy, a number of key issues and risks facing the Trust have been identified.

The Trust's Risk Register details a number of risks which may, should they be realised, impact on the delivery of high quality services and our strategic aims and objectives.

The Covid-19 pandemic has had a significant impact across the Trust's strategic risk profile. Strategic management of Covid-19 related risks has involved assurance and oversight functions performed by the Trust Executive Group and the Board of Directors. This has been achieved through in-year alignment of risks logged under incident control arrangements to key strategic risks included in the Integrated Risk and Assurance Report (IRAR).

The focus of the Trust's principal strategic risks will continue to be dominated by the impact of Covid-19. In describing our Principal Risks into 2021/22, the Board of Directors reflected on existing strategic risks, and the key issues that have impacted the Trust during the pandemic. This has been used to identify themes that are likely to affect the Trust in delivering its objectives or future success and sustainability.

Risks to the delivery of the best clinical outcomes

- Delayed treatment adversely impact health outcomes
- Operational pressures lead to sub-optimal care
- Staffing / skill mix not adequate to provide high quality services
- Increased rates of nosocomial infection lead to patient and staff harm
- Incomplete implementation of the current Electronic Patient Record (EPR) system results in lack of integrity of healthcare records

Risks to providing patient centred care

- Disparity between capacity and demand impacts waiting times and patient experience
- Covid-19 limits the effectiveness of strategic planning
- Inequalities and variation in care provision impact on provision of responsive, high quality care
- Ineffective system working leads to confusion, duplication and missed opportunities

- Ineffective governance arrangements leads to potential regulatory intervention and loss of public confidence

Risks to employing caring and cared for staff

- Staff health and wellbeing and resilience is negatively impacted
- Staff shortages puts pressure on teams and reduces capacity
- Insufficiently diverse and inclusive workforce affects service delivery
- Additional pressures on leadership of business continuity planning and delivery of core business

Risks to spending money wisely

- Failure to sustain financial stability due to an inability to predict future income
- Inability to appropriately identify and utilise capital monies in future years

Risks to delivery of excellent research, education and innovation

- Failure to identify and implement advantageous innovations leads to missed opportunities
- Focus of Trust research resources on Covid-19 studies displaces other research and reduces research funding
- Disruption of training programmes due to reduced placement provision and educational activity impacts our future workforce

Overview of Going Concern

After making enquiries Directors have a reasonable expectation that Sheffield Teaching Hospitals NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the Going Concern basis in preparing the accounts.

Analysis of Operational Performance

Sheffield Teaching Hospitals NHS Foundation Trust is one of the UK's busiest and most successful NHS foundation trusts. Above all, patients lie at the heart of everything we do.

Last year continued to be a challenging one for the NHS with all trusts expected to provide the highest standards of care whilst achieving demanding efficiency savings and responding to the Covid-19 pandemic.

Despite the enormous challenge of Covid-19, we treated around 70 per cent inpatients and day cases as well as almost 88 per cent outpatients compared to 2019/20. The number of attendances to our Accident and Emergency Department was at 77 per cent of 2019/20.

There are several national standards for waiting times, which we endeavour to achieve alongside this growth in activity whilst still ensuring the best possible patient care. We consider rigorous infection prevention and control and clean facilities to be fundamental to our care standards and we continue to work hard to minimise the chances of patients acquiring hospital acquired infections.

Further details of activity trends and the Trust's performance across key performance indicators are set out in the following tables:

Fig: Trust activity by activity type

Activity type	2016/17	2017/18	2018/19	2019/20	2020/21
Day cases	119,450	121,764	126,100	127,975	89,984
Elective Inpatient spells	31,787	30,065	29,236	28,857	19,151
Non-Elective spells	84,753	87,288	88,333	89,177	78,934
New Outpatient attendances	311,320	302,812	311,159	312,481	230,305
Follow up Outpatient attendances	765,669	778,084	803,395	803,815	750,270
Accident and Emergency attendances	147,643	149,531	156,967	158,561	121,300

Fig: 2020/21 Operational performance against key performance indictors

		2020/21 Performance			2020/21 Quarterly Trend			
		Target	Annual		Q1	Q2	Q3	Q4
Accident and Emergency (A&E)	95% of A&E patients wait less than four hours	95%	85.89%	●	93.27%	89.14%	80.55%	82.15%
Referral To Treatment	Patients waiting less than 18 weeks for treatment	92%	75.94%	●	75.45%	67.08%	80.47%	80.08%
Diagnostics	Patients waiting less than six weeks for diagnostic test	99%	69.94%	●	45.03%	71.95%	78.11%	84.74%
Cancelled Operations	Non Urgent operations cancelled on the day	N/A	0.30%		0.21%	0.28%	0.34%	0.32%
Cancer access initial appointment	Urgent GP referrals seen within two weeks	93%	95.9%	●	96.5%	96.9%	95.6%	94.9%
	Breast symptomatic referrals seen within two weeks	93%	92.0%	●	97.4%	91.6%	92.7%	89.2%
Cancer access initial treatments	First treatment within 31 days	96%	94.8%		93.6%	94.0%	95.5%	95.7%
	Treatment within 62 days of an urgent GP referral	85%	61.8%		67.6%	64.5%	59.3%	62.1%
	Treatment within 62 days of referral from screening	90%	60.0%		58.1%	19.4%	72.1%	67.0%
Cancer access subsequent treatments	Subsequent treatment (surgery) within 31 days	94%	87.3%	●	89.3%	83.0%	91.6%	87.5%
	Subsequent treatment (chemotherapy) within 31 days	98%	99.0%	●	96.4%	98.1%	99.5%	99.2%
	Subsequent treatment (radiotherapy) within 31 days	94%	96.1%	●	89.1%	94.2%	97.0%	97.4%
Infections	MRSA	0	2	●	1	1	0	0
	MSSA	63	65		12	17	17	19
	Clostridioides difficile (Community Onset)	48	46		6	15	13	12
	Clostridioides difficile (Hospital Onset)	108	105		24	24	34	23

Fig: Community performance 2020/21

Service measure	Target	Q1	Q2	Q3	Q4	2020/21
Intermediate Care Community Beds – number of admissions *(Includes SPARC - Excludes the Community Off Site 'Route 2' Beds)*	N/A	250	280	211	233	974
Intermediate Care Community Beds – Average Stroke Length of Stay	35 days	24.5	29.0	32.6	31.6	29.4
Intermediate Care Community Beds – Average Orthomedical Length of Stay	35 days	33.1	30.7	36.6	35.4	34
Intermediate Care at Home – Patients assessed within required timescales *(Data only available for Active Recovery Assessment and Community Stroke Service - Not ICT Active Recovery)*	98%	99.2%	96.4%	96.7%	96.26%	97.2%
Intermediate Care Number of packages delivered at home *(Active Recovery Assessment and Community Stroke Service and ICT Active Recovery)*	N/A	1,060	984	938	888	3,870
Community Nursing Referrals *(Includes additional information and resumptions)*	N/A	7,700	8,805	8,545	8,697	33,747
Community Nursing Contacts	N/A	162,435	176,512	180,605	166,721	686,273

Analysis of Financial Performance

As in many other areas of life, the 2020/21 financial year was a very unusual one due to the Covid-19 pandemic. Bespoke national financial arrangements were put in place to reflect the pandemic and best enable its management by NHS organisations. These were largely successful.

In simple terms, the financial arrangements for 2020/21 resulted in block contracts (fixed regardless of activity undertaken) with top-up funding to the level of expenditure in 2019/20 (plus inflation). Additional funding was then provided for the direct additional costs of the pandemic. In the first half of the year retrospective adjustments were made to ensure that funding covered costs, whereas in the second half of the year funding was fixed. There were clearly many operational and financial uncertainties throughout the year.

The Trust ultimately had a surplus from continuing operations of £13.5 million (1.0 per cent of turnover). The main driver behind this position was the savings from the lower levels of general activity undertaken in 2020/21 as a result of the pandemic. Turnover increased by 10.5 per cent to £1.3 billion, largely due to additional specific funding for managing the pandemic.

Pay costs rose by 8.1 per cent over 2019/20 levels and drugs costs by 9.8 per cent. Clinical supplies / services reduced by 20.7 per cent but general supplies and services, including personal protective equipment (PPE) costs, increased by 384 per cent. Premises costs, including IT, increased by 25.7 per cent and the clinical negligence premium increased by 30.5 per cent. The combined depreciation, loan interest and public dividend capital (PDC) dividend charges reduced by 7.1 per cent. Lower levels of general activity and the major impact of Covid-19 on services have driven a number of the variances above.

There was limited opportunity to drive normal cash releasing efficiency improvements but services still managed to deliver £5.1 million of savings over the year.

Capital Investment

Total capital expenditure for the year was £44.4 million and has been analysed below. The Trust again focussed on investing in the underlying, critical estate infrastructure whilst promoting new service developments and modernising theatres in order to improve the service to patients across the Trust. Inevitably, the Covid-19 pandemic has impacted the way in which the capital programme was delivered and also necessitated additional investment to support the Trust's Covid-19 response.

Fig: Capital investment 2020/21

	£,000	£,000
Medical Equipment	**9,272**	
Equipment replacement programmes (e.g. dialysis machines, patient monitoring equipment)		4,082
8th linear accelerator		2,002
Royal Hallamshire Hospital and Northern General Hospital plain film room equipment		908
Royal Hallamshire Hospital symptomatic and assessment mammography equipment		578
Royal Hallamshire Hospital fluoroscopy replacement rooms (x2)		495
Other		1,207
Information Technology	**2,463**	
IT infrastructure (including server virtualisation expansion)		1,620
Other		843
Service Development	**8,184**	
Clinical Immunology and Allergy Unit expansion		1,838
Community dental services		1,508
Hyper Acute Stroke Unit		1,443
Musculoskeletal Hub		814
Purchase of Longley Lane		781
5 Beech Hill Road refurbishment		633
Other smaller schemes / adjustments		1,167
Infrastructure	**18,365**	
Royal Hallamshire Hospital A Floor theatres		4,858
Northern General Hospital Firth Wing theatres		2,357
Royal Hallamshire Hospital main lifts		1,562
Northern General Hospital low voltage generators		1,200
Other		8,388
Covid-19	**6,153**	
Medical equipment, plant and IT		5,286
Buildings		867
Total Expenditure	**44,437**	

The capital expenditure was partially funded by internally generated resources and partially funded by a range of additional public dividend capital (PDC) allocations in-year. The final expenditure was within the approval limit notified by the South Yorkshire and Bassetlaw Integrated Care System (ICS) during 2020/21.

Cash Flow and Balance Sheet

The Trust's net assets employed at 31 March 2021 were £436.9 million compared with £398.1 million at the previous year-end. The value of Land, Buildings and Equipment at 31 March 2021 was £415.6 million with the increase in 2020/21 reflecting the high level of capital expenditure referred to above. Outstanding borrowings relating to loans, a public finance initiative (PFI) contract and a finance lease totalled £35.1 million at the year-end (a reduction of £2.4 million).

Cash balances increased to £186.3 million at 31 March 2021 (£90.8 million at 31 March 2020) and net current assets at 31 March 2021 increased to £54.1 million (from £34.4 million at 31 March 2020), predominantly due to the income and expenditure surplus referred to above. A significant amount of the balances are committed to capital schemes and research projects in future years. The Trust has also aspired, as a foundation trust, to have a sound working capital position in order to provide a degree of financial security and ensure the continuity of patient services.

Conclusion

Clearly 2020/21 has been an exceptional year in every respect. It has been a challenging year for financial management but the Trust has maintained financial control and supported services in managing the Covid-19 pandemic and maintaining other services as much as possible. The on-going implications of the pandemic will continue to need financial management. However, the Trust equally recognises that normal financial arrangements will return in the near future and that it needs to ensure that it is prepared for this.

Performance Report signed by the Chief Executive in capacity as Accounting Officer

Kirsten Major
Chief Executive
11 June 2021

Accountability Report

Directors' Report

The Directors' report is presented in the name of the Directors of the Board of Directors.

Composition of the Board of Directors

Led by a Non-Executive Chair, the Board of Directors comprises of eight other Non-Executive Directors and up to eight Executive Directors, including the Chief Executive. The individuals occupying position on the Board during 2020/21 are listed below with their attendance at Board meetings recorded later in this report.

Annette Laban, Trust Chair, appointed 1 January 2021

Annette was appointed to the Board as a Non-Executive Director in July 2013 and was appointed Trust Chair from 1 January 2021.

Annette has more than 35 years' experience working in senior positions within the NHS and local government. Throughout her career she has been responsible for overseeing many innovations which have directly impacted on frontline NHS care. Her past roles have included Chief Executive for NHS Doncaster, Director of Performance and Operations at NHS North of England Strategic Health Authority and Executive Director of Performance and Delivery at NHS Yorkshire and the Humber.

Tony Pedder OBE, Trust Chair, term of office ended 31 December 2020

Tony joined the Trust as Chair in January 2012. He was previously the Chair of NHS Sheffield and also the Chair of South Yorkshire and Bassetlaw Cluster of NHS Primary Care Trusts. Tony was previously Chief Executive of Corus plc. As well as his NHS experience, he brought extensive management and operational experience to the role from a variety of business organisations and markets. While Trust Chair, Tony was also Pro-Chancellor and Chair of Council at The University of Sheffield.

Other Non-Executive Directors

Tony Buckham, Vice Chair, appointed 1 September 2015

Tony brings a wealth of experience from his time working within complex global organisations. He has provided strategic support to the HSBC Group Management Board Directors, with particular expertise within IT and Corporate Real Estate for over 10 years. Tony has led divisions of up to 7,000 staff with particular focus on people development to enable global transformational change. He has also made a significant contribution to mentoring and coaching programmes.

Professor Chris Newman, Non-Executive Director, appointed 1 November 2017

Chris joined the Board in November 2017. He is Interim Vice President and Head, Faculty of Medicine, Dentistry and Health at the University of Sheffield, Dean of the Medical School, Professor of Clinical Cardiology and Honorary Consultant Cardiologist at the Trust. He also directs the National Institute for Health Research Sheffield Clinical Research Facility, a joint facility between the Trust and The University of Sheffield.

John O'Kane, Non-Executive Director, appointed 1 October 2014

John is an experienced Finance Director, with experience of managing change in a number of companies. He has worked as Group Finance Director at Redhall Group, Jarvis, Ecobat Technologies, Peterhouse Group and Kelda Group. John is also a Trustee of the Sheffield Hospitals Charity.

Rosamond Roughton, Non-Executive Director appointed 1 December 2019

Rosamond brings widespread experience of working in policy at national level, as well as experience at board level in the NHS. Most recently, she was the Director of Adult Social Care at the Department of Health and Social Care (DHSC). Her membership of the Board of Directors was paused during 2020 to enable her to focus on the support needed for social care at the start of the Covid-19 pandemic. She stepped down from her role at the Department in the summer of 2020 in order to care and support her parents. Following the death of her father in January 2021, she is now the full time carer for her mother who is living with dementia.

Prior to her DHSC role, Rosamond was an Executive Director at NHS England, where from 2014 she had national responsibility for general practice and primary care services; and the commissioning of armed forces healthcare, national screening and immunisation programmes, healthcare for people in the criminal justice system, and sexual assault referral services. She started her working life as a civil servant, working at the Treasury and then Department of Health. Her NHS career has also included roles such as Director of Workforce and HR at the Christie Hospital NHS Trust and Director of Strategy for Yorkshire and the Humber NHS. She is an honorary fellow of the Royal College of General Practitioners.

Martin Temple, Non-Executive Director, appointed 1 July 2013

Martin was Chair of the Health and Safety Executive until August 2020 after an extended term.

Martin has served on the boards of a wide range of companies around the world, including the Board of The Great Exhibition of the North. He was Chairman of the Design Council, on the Council of the University of Warwick as well as the Chair of the Warwick Business School Advisory Board. He has also been Vice President of Avesta-Sheffield AB, Director-General of EEF and more latterly Chair, and a Non-Executive Director and Chairman of the 600 Group PLC.

Martin has extensive experience covering senior roles in production, marketing, operations and strategy in an international context.

Shiella Wright, Non-Executive Director, appointed 1 April 2019

Shiella joined the Board in April 2019, bringing with her over 11 years' experience as a NHS Non-Executive Director. She has served on several public and voluntary sector boards, is the current Chair of Age UK Nottingham and Nottinghamshire and an Independent Member of the Parole Board for England and Wales. She is a member of the South Yorkshire Police Commissioner Independent Ethics Panel, and a Commissioner of Sheffield Council for Race Equality.

Shiella is the former Deputy Chief Executive, Director of Operations of Nottinghamshire Probation Trust. She has developed and delivered transformational change, in particular organisational development, performance and leadership. She has also developed and delivered a mentoring scheme for under-represented groups, which has been adapted by NHSI for its NExT Director Scheme.

Shiella hails from Sheffield and has worked in many executive roles across Yorkshire and Humberside.

Executive Directors

Kirsten Major, Chief Executive

Kirsten joined Sheffield Teaching Hospitals in March 2011 as Director of Strategy and Planning. She was appointed as Deputy Chief Executive in 2017 and took up the position of Interim Chief Executive in August 2018, prior to being appointed to the role substantively from March 2019. Since January 2020 Kirsten has also held the position of Non-Executive Director at the York Health Economics Consortium (YHEC). Kirsten has recently been appointed as a Trustee at Sheffield Theatres Trust and will take up this appointment in May 2021.

Kirsten has held a number of other director-level positions within the NHS, including Health Boards in Scotland and at the North West Strategic Health Authority. Kirsten is a health economist by profession and was active in a range of professional and research based collaborations.

Anne Gibbs, Director of Strategy and Planning

Anne was appointed in February 2018, prior to which she worked for NHS Improvement in a joint role with Greater Manchester Health and Social Care Partnership. Previously, she has worked at Board level for a number of trusts in London and Birmingham.

Mark Gwilliam, Director of Human Resources and Staff Development

Mark is Director of Human Resources and Staff Development. He took up his original post as Director of Human Resources and Organisational Development in May 2009 bringing with him a wealth of experience.

He was previously an Associate Director of Human Resources at Central Manchester University Hospitals NHS Foundation Trust. Mark joined the NHS in 2004 through the Gateway to Leadership Programme and was assigned on placement at Sheffield Teaching Hospitals NHS Foundation Trust. Prior to this he worked in the fast moving consumer goods sector in numerous operational management and human resource management roles.

Michael Harper, Chief Operating Officer

Michael joined the Northern General Hospital from the General NHS Management Training Scheme in 2000. He has worked in a number of operational leadership roles in A&E, Medicine, Cardiothoracics, Orthopaedics and Surgical Services throughout the Trust since this time.

He became Chief Operating Officer in January 2015 and has attended Board meetings as a Participating Director since August 2018. From June 2019, the position of Chief Operating Officer has been an Executive member of the Board of Directors.

David Hughes, Medical Director (Development)

David joined the Trust in February 2005 as Consultant Histopathologist having previously worked as a Consultant at Chesterfield Royal Hospital and the Royal Orthopaedic Hospital, Birmingham.

David has previously worked as Associate Medical Director - Cancer, Deputy Medical Director and Responsible Officer at the Trust and worked for the National Cancer Research Institute, Royal College of Pathologists, North Trent Cancer Network and National Cancer Action Team.

Jennifer Hill, Medical Director (Operations)

Jennifer joined the Trust in 1999 as Consultant Respiratory Physician having trained in Nottingham, Leeds and Glasgow. Jennifer was Trust Multi-Disciplinary Team Lung Cancer Lead, Network Lung Cancer Lead, Clinical Director for Respiratory Medicine and Deputy Medical Director before taking up her post of Interim Medical Director (Operations) in February 2020, attending Board meetings as a Participating Director.

Jennifer was appointed to this role substantively from December 2020 when the position of Medical Director (Operations) became an Executive member of the Board of Directors.

Chris Morley, Chief Nurse

Chris joined the Trust as Chief Nurse in October 2018 from The Rotherham NHS Foundation Trust where he also held the position of Chief Nurse. Prior to this Chris was Deputy Chief Nurse here at Sheffield Teaching Hospitals.

He has previously held a number of leadership roles in healthcare governance, patient safety and nursing management. Chris is a Visiting Professor in the College of Health, Wellbeing and Life Sciences at Sheffield Hallam University.

Neil Priestley, Director of Finance

Neil was appointed to the post of Director of Finance of the newly merged Sheffield Teaching Hospitals in February 2001. He had previously held the post of Head of Finance at the NHS Executive Trent Regional Office, from where he had been seconded to the Northern General Hospital as acting Director of Finance prior to the Trust merger.

Neil is a Fellow of the Chartered Association of Certified Accountants.

Other senior managers who attend Board as Participating Directors

Paul Buckley, Interim Director of Strategy and Planning (from September 2020)

Paul joined the NHS in 1996 and has worked in a range of senior operational, project and strategic leadership roles. From September 2020 Paul has attended meetings of the Board of Directors in his capacity as Interim Director of Strategy and Planning. Paul has held his substantive role within the Trust as Deputy Director of Strategy and Planning since October 2013.

Sandi Carman, Assistant Chief Executive

Sandi has over 25 years' experience working in NHS acute, community, and commissioning organisations. Sandi's career started in Occupational Therapy at the Northern General Hospital and she has since gained a wealth of experience in operational and corporate leadership roles.

Sandi is a Non-Executive Director for South Yorkshire Housing Association, Director for Legacy Park Limited and a Joint Independent Audit Committee Member for the South Yorkshire Police and Crime Commissioner.

Julie Phelan, Communications and Marketing Director

Julie spent her early career as a journalist in both print and broadcast media before moving into public sector communication in local government and health. She was previously Head of Communications at Sandwell and West Birmingham Hospitals NHS Trust, Head of Communications for Birmingham Women's Hospital and Director of Communications for Worcestershire Acute Hospitals and Worcester Health Authority. Before joining the Trust in June 2008, Julie was Director of Communications for University Hospitals Coventry and Warwickshire NHS Trust.

Statement on the balance, completeness and appropriateness of the membership of the Board

The Board of Directors' Nomination and Remuneration Committee has carried out an in-year review of the composition of the Board. This has been in the context of current and anticipated issues and challenges impacting the Trust, and the skills and qualities needed on the Board. This exercise is undertaken routinely as part of the process of considering appointments and reappointments to the Board.

As outlined in the above biographies, the Board comprises individuals with senior level experience in the public and private sectors, across a range of disciplines including clinical and patient care, finance, strategic and operational planning, commercial development, governance, risk management, human resources and change management.

The Board is satisfied that its current membership allows it to function effectively.

All Directors on the Board of Directors have, on appointment, confirmed that they met the Fit and Proper Persons Test and complete an annual declaration confirming that they continue to be a fit and proper person in accordance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 5: Fit and Proper Persons Requirement.

Board members Register of Interests and Gifts and Hospitality

Company directorships and other declarations including receipt of gifts and hospitality were declared by all Board members. The Trust has updated its Standards of Business of Conduct Policy to reflect guidance from NHS England and the full register of interests can be accessed from the following link.

The Board has determined that the current Chair and all Non-Executive Directors are independent in character and judgement. This includes the appointed representative of The University of Sheffield, Professor Chris Newman, Dean of the Medical School, notwithstanding the Trust's relationship during this reporting period with The University of Sheffield.

Arrangements in place to ensure that the Trust is well-led

Review of the effectiveness of the Board of Directors and the outcomes from assessment of performance is used to inform ongoing development of the Board. This is done both collectively, and of individual Board members, as part of a formal annual appraisal system and the review and agreement of a Board work programme for the year.

The Board has undertaken in-year self-assessment of its leadership and governance arrangements against governance best practice, using well-led guidance[1] to inform the continued development of the Trust's governance arrangements.

The Board of Directors keeps the performance of its committees under regular review and requires that each committee assesses how it discharges the responsibilities outlined in its terms of reference. The Board reviews these annually and agrees any objectives for the forthcoming year.

The Board's most recent well-led self-assessment in April 2018, involved facilitated self-assessment supported by our internal auditors. Board member survey work and one-to-one interviews with lead Executive Directors complemented a desktop review of evidence. This generated for discussion with the Board a baseline assessment of Trust compliance for each key line of enquiry.

Under transitional monitoring review arrangements introduced by the CQC during 2020/21 the Trust has participated in a review against the CQC well-led domain. The review took place virtually with no matters raised for immediate escalation.

Financial and other public interest disclosures

Cost allocation and charging requirements

Sheffield Teaching Hospitals NHS Foundation Trust has complied with the cost allocation and charging guidance issued by HM Treasury. There are no additional charges made for material made available to meet the needs of particular groups of people, for example, in Braille or other languages. Following the introduction of the General Data Protection Regulation and the UK Data Protection Act 2018 in May 2018, fees, as set by the Information Commissioner's Office, are no longer chargeable for subject access requests for personal data, including copies of medical records. Similarly, no fees are chargeable for the supply of medical records of deceased patients under the auspice of the Access to Health Records Act 1990. The Trust does not impose any fees for responding to requests under the Freedom of Information Act unless the amount of information exceeds the appropriate limit as defined in section 12 of the Freedom of Information Act.

[1] Development reviews of leadership and governance using the well-led framework: guidance for NHS trusts and NHS foundation trusts (Jun 2017)

Political donations

There are no political donations to disclose.

Employee benefits

Accounting policies for pensions and other retirement benefits are set out in note 1.6 of the accounts. Details of senior employee's remuneration can be found in the Remuneration Report section of this Annual Report.

Non-NHS income

As required by Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012), the Directors confirm that the income that the Trust has received from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purposes.

In addition to the above, the Directors confirm that the provision of goods and services for any other purposes, has not materially impacted on our provision of goods and services for the purposes of the health service in England. Further details of the income sources to the Trust can be found in note 3.2 of the accounts.

Payment of creditors

The Trust aims to comply with the Better Payment Practice Code. Performance for the financial year is set out in note 6 of the accounts.

Remuneration Report

The Remuneration Report outlines appointments and payments made in-year to Trust Executive Directors, Non-Executive Directors and the Trust's most senior employees and includes the senior managers' remuneration policy.

Annual statement on remuneration

I am pleased to present the Remuneration Report for the financial year 2020/21 on behalf of the Board of Directors' Nomination and Remuneration Committee.

The Committee is responsible for making decisions on matters relating to the nomination, appointment, remuneration and terms and conditions of office of the Trust's Executive Directors and other individuals on locally-determined pay, including salary, pensions, termination and / or severance payments and allowances.

In discharging its responsibility for setting the remuneration and conditions of service for the Trust's most senior managers, its key objective is to ensure that the remuneration packages are sufficient to recruit and retain individuals of the calibre required for the successful operation of the Trust, while avoiding paying excessively for this purpose.

There have been no changes made to the Trust's remuneration policy for senior managers in 2020/21. Decisions made in line with this policy during the past year or impacting on this reporting period are outlined here.

At the end of 2019/20 at its meeting held on 31 March 2020 the Committee considered and approved a 2020/21 pay award for very senior managers, staff on ad hoc spot salaries, and for application to management responsibilities, consistent with that made to staff on Agenda for Change terms and conditions of service.

It also agreed that an equivalent cost of living uplift should be awarded to Executive Directors.

At this meeting the Committee was also asked to consider extending the learning account funds to four substantive Clinical Directors. This was to bring their remuneration packages in line with those of Nurse Directors and Operations Directors at the Trust. The recommendation was agreed by the Committee.

There has been one substantive change to the Executive composition of the Board of Directors during 2020/21. At its meeting held on 22 September 2020, the Committee agreed a proposal for making the previous interim arrangements for a Medical Director (Operations) into a permanent position, and for it to become an additional Executive member of the Board, leading on the healthcare governance and medical workforce aspects of the Medical Director portfolio. The interim position had been created in February 2020, to facilitate the existing Medical Director to give more focused leadership to the expanding technology, research and innovation agendas. As a result of this

substantive appointment the existing role of Medical Director was redefined as Medical Director (Development).

A recommendation was made and approved for the remuneration of the newly appointed substantive Medical Director (Operations) which was consistent with the salary range approved by the Committee in October 2019 when recruiting to the interim position. It also took into account NHSI's recommended pay range for Medical Directors employed by trusts of a similar size and complexity.

Following a formal recruitment process the incumbent post holder, Jennifer Hill, was appointed to the position of Medical Director (Operations) with Executive accountabilities from 1 December 2020.

The Committee also noted the formalisation of interim cover arrangements for the post of Director of Strategy and Planning. From September 2020 Paul Buckley has attended meetings of the Board of Directors, in his capacity as Interim Director of Strategy and Planning, to cover the long term absence of the substantive postholder. A recommendation from the Chief Executive for a supplementary payment in respect of additional responsibilities was agreed by this Committee.

In-year the Committee was also asked to give consideration to matters relating to the impact of pension tax changes on specific clinical staff, harmonisation of on-call rates, and remuneration for out-of-hours shifts undertaken by Accident and Emergency Consultants. In each case the Committee agreed recommendations supported by the Trust Executive Group.

At its meeting held on 3 March 2021, the Committee considered and agreed a recommendation from Gold Command to make a £100 one-off thank you payment to all staff. This was to acknowledge the extraordinary efforts of the whole workforce in responding to and managing the pressures of the Covid-19 pandemic.

Annette Laban

Chair of the Board of Directors' Nomination and Remuneration Committee

Senior managers' remuneration policy

The remuneration of the Chief Executive and Executive Directors is determined by the Board of Directors' Nomination and Remuneration Committee taking into account market levels, key skills, performance and responsibilities.

The Trust's overarching approach is to ensure that senior managers' remuneration supports delivery of our vision to be recognised as the best provider of healthcare, clinical research and education in the UK, and a strong contributor to the aspiration of Sheffield to be a vibrant and healthy city region.

As such, the principle underpinning the Trust's remuneration policy is that rewards to senior managers should enable the Trust to recruit, motivate and retain individuals with the necessary skills, experience and ability, to support delivery of the Trust's strategic objectives.

Future policy table senior managers (other than Non-Executive Directors)

Executive Director remuneration for 2020/21 was set at an appropriate level to recognise the significant responsibilities of directors in foundation trusts of similar size and complexity, and to attract and retain individuals with the necessary skills, experience and ability.

The future policy table overleaf provides detail on each element of Executive Directors' remuneration packages for 2020/21, how the level of pay is determined, how change is enacted and how Executive Directors' performance is managed.

Directors with remuneration (total) greater than £150,000

The Trust takes steps to assure itself that remuneration is set at a competitive rate in relation to other similar NHS foundation trusts, and that this rate enables the Trust to attract and retain senior managers with the necessary abilities to lead and develop the Trust's activities fully for the benefit of patients. In making decisions about whether to pay any individual Executive Director more than £150,000[2] per annum, as outlined in guidance issued by the Cabinet Office, regard is paid to remuneration benchmarking data, market conditions, and the individual Director's level of experience and development of the role.

[2] *The threshold set out in NHSI guidance above which NHS foundation trusts should make a disclosure.*

Fig: Future policy table

How the component supports the strategic aims of the Trust	How the component operates	Maximum potential value of the component	Description of framework used to access performance
Base pay			
Base pay is determined using benchmarked data (reviewed annually) in order to attract, reward and retain individuals of the right calibre to lead the delivery of the Trust's aims and priorities.	Salaries are reviewed annually and any changes are normally effective from 1 April each year. Such changes are proposed and made via the Board's Nomination and Remuneration Committee, chaired by a Non-Executive Director. In exceptional circumstances, reviews of salary may be made outside of this cycle, but are made by the Nomination and Remuneration Committee.	Change to basic salary is usually enacted as a percentage increase in line with national Agenda for Change pay arrangements, to ensure parity across the Trust (senior managers are proportionally not treated more favourably than other staff).	The Chief Executive and the Executive Directors participate in annual performance reviews undertaken by the Trust Chair and Chief Executive respectively. The individual's agreed objectives are linked to the Trust's corporate objectives. The Trust does not operate a system of performance related pay. Failure to meet objectives is managed via our Trust policies and performance frameworks.
Pension-related benefits			
Pension benefits (which may be opted out of) are part of the total remuneration of directors to attract high-calibre staff to enable the Trust to meet its strategic objectives.	Pension is available as a benefit to directors and follows national NHS Pension Scheme contribution rules (or alternative pension provider).	Pension is available as a benefit to directors and follows national NHS Pension Scheme contribution rules (or alternative pension provider). Pension entitlements are determined in accordance with the HMRC method.	Not applicable.
On-call payment			
Senior managers receive on-call payment in line with on-call responsibilities.			
Learning account funds			
Senior managers at Directorate Triumvirate level (Nurse Directors, Operations Director and substantive Clinical Directors) receive learning account funds as part of their remuneration package.			
Benefits			
The Trust operates a number of salary sacrifice schemes including childcare vouchers, white goods scheme and a lease car scheme. These are open to all members of staff.			
Travel expenses			
Appropriate travel expenses are paid for business mileage.			
Covid-19 thank you gift			
A £100 one-off thank you payment to all staff in 2020/21.			

Payments for loss of office

There is no entitlement to any additional remuneration in the event of early termination. During 2020/21 no senior manager (or past senior manager) received payments for loss of office*.

* subject to audit

Statement of consideration of employment conditions elsewhere in the Trust

In determining the pay and conditions of employment for Executive Directors and senior managers, the Board of Directors' Nomination and Remuneration Committee takes account of national pay awards given to medical and non-medical staff groups subject to national Agenda for Change, or national Medical and Dental Terms and Conditions.

The Trust did not consult with employees when preparing the senior managers' remuneration policy, however annual benchmarked data from comparative teaching hospitals provided by NHS Providers, was used to determine the appropriate remuneration for Executive and Non-Executive Directors during the year.

Policy on diversity and inclusion used by the Nomination and Remuneration Committee

The Board is committed to ensuring that its composition comprises an appropriate balance of skills, knowledge and experience. Diversity is a vital part of the continued assessment and enhancement of board composition, and the Board recognises the benefits of diversity amongst its members.

Appointments to the Board of Directors are subject to a formal, rigorous and transparent procedure. While new appointments are always based on merit, careful consideration is given to the benefits of improving and complementing the diversity, skills, experience and knowledge of the Board. Under the Trust's equality, diversity and inclusion (EDI) work programme, representative recruitment panels have been introduced during 2020/21 to ensure ethnicity and gender representation throughout recruitment processes.

Before any appointment is made to the Executive team, the Board of Directors' Nomination and Remuneration Committee evaluates the balance of skills, knowledge, experience and diversity. In the light of the evaluation, it reviews a description of the role and capabilities required for a particular appointment. The Committee ensures that the appointment process is designed to attract the best candidates, through the use of a range of open advertising or the services of external advisers to facilitate the search.

Likewise, at the outset of each and every Non-Executive Director recruitment and selection process, the Council of Governors' Nomination and Remuneration Committee reviews the composition of Board of Directors for balance of diversity, skills and experience to inform its search.

Annual report on remuneration 2020/21

Service contract obligations

None of the current substantive Executive Directors are subject to an employment contract that stipulates a length of appointment. The appointment of the Chief Executive is made by the Non-Executive Directors and approved by the Council of Governors. In order to attract Executive Directors of sufficient calibre, the Chief Executive and Executive Directors have permanent employment contracts with appropriate notice periods in line with employment law, rather than a fixed term. This is in line with similar contracts in the sector. The process to recruit to Executive Director positions involves the Chair, Chief Executive and Non-Executive Directors.

The following table contains details of the service contracts in place during 2020/21 for Executive Directors.

Fig: Service contracts

Name	Date of service contract	Unexpired term	Notice period
Anne Gibbs	February 2018	Open ended	6 months
Mark Gwilliam	May 2009	Open ended	3 months
Michael Harper	June 2019	Open ended	6 months
Jennifer Hill	December 2020	Open ended	6 months
David Hughes	February 2019	Open ended	6 months
Kirsten Major	March 2019	Open ended	6 months
Chris Morley	October 2018	Open ended	6 months
Neil Priestley	February 2001	Open ended	3 months

The Board of Directors' Nomination and Remuneration Committee

The Board of Directors' Nomination and Remuneration Committee is chaired by the Trust Chair and its membership includes all Non-Executive Directors.

The role of the Committee is outlined in its terms of reference which are annually reviewed and approved by the Board of Directors. Its responsibilities in relation to remuneration are to:

- Decide upon and review the terms and conditions of the office of the Trust's Executive Directors and most senior employees, in accordance with all relevant Trust policies, including:
  - Salary, including any performance-related pay or bonus
  - Provision for other benefits, including pensions
  - Allowances
- Monitor and evaluate the performance of individual Executive Directors
- Adhere to all relevant laws, regulations and Trust policy in all respects, including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate Executive Directors whilst remaining cost effective
- Advise upon and oversee contractual arrangements for Executive Directors, including (but not limited to) termination payments and agreements. This also relates to any matter that requires Treasury approval, or any matter that may give rise to public concern
- Determine arrangements for annual salary review for all staff on Trust contracts

The Committee met a total of six times during 2020/21, attendance at which was recorded.

Fig: Board of Directors' Nomination and Remuneration Committee membership and attendance

Name	Attendance (actual / possible)
Tony Pedder, Chair until 31 December 2020	3 from 3
Annette Laban, Chair from 1 January 2021, previously Non-Executive Director	6 from 6
Tony Buckham	5 from 6
Chris Newman	4 from 6
John O'Kane	6 from 6
Rosamond Roughton	4 from 6
Martin Temple	6 from 6
Shiella Wright	4 from 6

At the invitation of the Committee, meetings are attended by the Chief Executive, the Director of Human Resources and Staff Development, and the Assistant Chief Executive, who acts as Committee Secretary. Executive Directors are not involved in any decisions or discussions regarding their own remuneration.

The remuneration of Non-Executive Directors is the responsibility of the Council of Governors' own Nomination and Remuneration Committee. The work of this Committee is outlined within the Governance section of this Annual Report.

Disclosures required by the Health and Social Care Act

Expenses for Executive and Non-Executive Directors

The expenses for Executive and Non-Executive Directors and Governors are reimbursed on a receipts basis, evidencing the business mileage or actual travel / subsistence costs incurred. Reimbursement rates for mileage are those applied to all Trust employees and do not exceed national guidelines.

Total expenses for 2020/21 are detailed in the table below:

Fig: Expenses for Executive and Non-Executive Directors and Governors

	2020/21	2019/20
Executive and Non-Executive Directors		
Number who claimed expenses during the year	3	10
Number of Executives / Non-Executives who held office during the year	16	16
Amount claimed in total	£492.80	£8,441.77
Governors		
Number who claimed expenses during the year	4	13
Number of Governors who held office during the year	36	29
Amount claimed in total	£273.84	£5,095.76

Remuneration of Executive and Non-Executive Directors

In reporting on remuneration within the tables provided on pages 43 and 44, the Trust has applied the definition of senior managers, as proposed within the NHS Foundation Trust Annual Reporting Manual, and included senior managers who influence the decisions of the Trust, rather than the decisions of individual directorates or sections of the Trust. As well as referring to Executive and Non-Executive Directors, this extends to the Assistant Chief Executive, and the Communications and Marketing Director. In addition this applied to the Interim Medical Director (Operations) role for its duration in 2020/21 (1 April 2020 to 30 November 2020) and this includes the post of interim Director of Strategy and Planning.

Table 1 - Single total remuneration for senior managers

		Single Total Remuneration 2020/21			Single Total Remuneration 2019/20		
Name	Title	Salary Bands of £5,000	All pension related benefits Bands of £2,500	Single Total Remuneration Bands of £5,000	Salary Bands of £5,000	All pension related benefits Bands of £2,500	Single Total Remuneration Bands of £5,000
Tony Buckham	Non-Executive Director and Vice Chair	15 - 20	-	15 - 20	15 - 20	-	15 - 20
Paul Buckley[a]	Interim Director of Strategy and Planning (from 3 Sept 2020)	110 - 115	27.5 - 30	135 - 140	-	-	-
Sandi Carman	Assistant Chief Executive	110 - 115	27.5 - 30	140 - 145	110 - 115	22.5 - 25	135 - 140
Anne Gibbs	Director of Strategy and Planning	135 - 140	37.5 - 40	175 - 180	145 - 150	30 - 32.5	175 - 180
Mark Gwilliam	Director of Human Resources and Staff Development	175 - 180	32.5 - 35	205 - 210	170 - 175	37.5 - 40	210 - 215
Michael Harper	Chief Operating Officer	140 - 145	52.5 - 55	195 - 200	130 - 135	65 - 67.5	200 - 205
Jennifer Hill[b]	Medical Director (Operations)	185 - 190	177.5 - 180	360 - 365	175 - 180	112.5 - 115	290 - 295
David Hughes	Medical Director (Development)	175 - 180	42.5 - 45	220 - 225	170 - 175	302.5 - 305	475 - 480
Candace Imison	Non-Executive Director (to 31 August 2019)				5 - 10	-	5 - 10
Annette Laban	Chair (from 1 Jan 2021) / Non-Executive Director (to 31 Dec 2020)	25 - 30	-	25 - 30	15 - 20	-	15 - 20
Kirsten Major	Chief Executive	225 - 230	60 - 62.5	290 - 295	220 - 225	110 - 112.5	335 - 340
Chris Morley	Chief Nurse	150 - 155	35 - 37.5	185 - 190	150 - 155	147.5 - 150	300 - 305
Chris Newman	Non-Executive Director	15 - 20	-	15 - 20	15 - 20	-	15 - 20
John O'Kane	Non-Executive Director	15 - 20	-	15 - 20	15 - 20	-	15 - 20
Tony Pedder	Chair (to 31 December 2020)	40 - 45	-	40 - 45	55 - 60	-	55 - 60
Julie Phelan	Communications and Marketing Director	115 - 120	30 - 32.5	150 - 155	115 - 120	30 - 32.5	145 - 150
Neil Priestley	Director of Finance	190 - 195	-	190 - 195	190 - 195	-	190 - 195
Rosamond Roughton[c]	Non-Executive Director (from 1 December 2019)	-	-	-	-	-	-
Martin Temple	Non-Executive Director	15 - 20	-	15 - 20	15 - 20	-	15 - 20
Shiella Wright	Non-Executive Director (from 1 April 2019)	15 - 20	-	15 - 20	15 - 20	-	15 - 20

[a] Paul Buckley's total remuneration for 2020/21 includes an amount of £41k remuneration in respect of his substantive role prior to undertaking the role of Interim Director of Strategy and Planning from September 2020.
[b] Jennifer Hill was appointed to the Executive Director position of Medical Director (Operations) from 1 December 2020 following undertaking the role on an interim basis and attending Board meetings as a Participating Director from 1 February 2020. Jennifer Hill's 2020/21 remuneration is inclusive of an amount of £87k remuneration in respect of clinical duties undertaken in her role prior to her appointment to the substantive position of Medical Director (Operations).
[c] Rosamond Roughton has chosen not to receive remuneration for her role whilst being employed as a senior civil servant.

Notes on Table 1: No remuneration is paid to any Director by way of any taxable expense payment nor by any form of performance related pay or bonuses. Pension related benefits have been calculated using the HRMC method advised by NHSI in the Annual Reporting Manual. Table 1 subject to audit.

Table 2 - Total pension benefits

	Real increase in pension at pension age (£'000)	Real increase in pension lump sum at pension age (£'000)	Total Accrued pension at pension age at 31.03.21 (£'000)	Lump sum at pension age related to accrued pension at 31.03.21 (£'000)	CETV at 31.03.20 (£'000)	Real Change in CETV (£'000)	CETV at 31.03.21 (£'000)
	Bands of £2,500	Bands of £2,500	Bands of £5,000	Bands of £5,000	(£,000)	(£,000)	(£,000)
Paul Buckley, Interim Director of Strategy and Planning (from 3 Sept 2020)	0 - 2.5	0 - 2.5	35 - 40	80 - 85	625	15	678
Sandi Carman, Assistant Chief Executive	0 - 2.5	0 - 2.5	40 - 45	90 - 95	728	29	785
Anne Gibbs, Director of Strategy and Planning	2.5 - 5	0 - 2.5	50 - 55	100 - 105	743	31	807
Mark Gwilliam, Director of Human Resources and Staff Development	2.5 - 5	0 - 2.5	40 - 45	90 - 95	784	36	858
Michael Harper, Chief Operating Officer	2.5 - 5	2.5 - 5	40 - 45	80 - 85	568	38	635
Jennifer Hill, Medical Director (Operations) (from 1 Dec 20)	7.5 - 10	20 -22.5	65 - 70	165 - 170	1,218	182	1,450
David Hughes, Medical Director (Development)	2.5 - 5	0 - 2.5	50 - 55	140 - 145	1,084	51	1,179
Kirsten Major, Chief Executive	2.5 - 5	0 - 2.5	70 - 75	140 - 145	1,108	51	1,211
Chris Morley, Chief Nurse	2.5 - 5	0 - 2.5	65 - 70	170 - 175	1,216	43	1,302
Julie Phelan, Communications and Marketing Director	0 - 2.5	0 - 2.5	45 - 50	95 - 100	794	34	858

Notes on Table 2: The Trust is a member of the NHS Pension Scheme which is a defined benefit Scheme, though accounted for locally as a defined contribution scheme. The Trust does not operate nor contribute to a stakeholders pension scheme. Non-Executive Directors are not members of the Trust pension scheme. Disclosure is made in respect of pension benefits for those Directors who were active members of the NHS Pension Scheme during 2020/21 and whose membership was active at 31 March 2021. CETV (Cash Equivalent Transfer Value) is the value of a member's pension fund at 31 March if he/she were to transfer that pension fund on that date. Benefits and related CETVs do not allow for a potential future adjustment arising from the McCloud Judgement and the Guaranteed Minimum Pension (GMP) Judgement.

Table 2 subject to audit.

Hutton Report Disclosure

The Trust is required to disclose the relationship between the remuneration of the highest paid director in their organisation, and the median remuneration of the organisation's workforce, at the reporting period end date on an annualised basis.

The banded remuneration of the highest paid director in the Trust in the financial year 2020/21 was £227.5k, compared with £222.5k in 2019/20. This was 8.07 times the median remuneration of the workforce, which was £28,346.

The decline in the ratio in 2020/21 reflects the increase in the median remuneration of the workforce, largely as a result of increased additional hour payments made to staff in response to the Covid-19 pandemic. The remuneration of the highest paid director has increased by an amount that was consistent with the annual pay award made to staff on Agenda for Change terms and conditions of service.

Table 3 - Fair pay multiple statements

	2020/21	2019/20	2018/19
Band of highest paid director's total remuneration (midpoint banded remuneration in multiples of £5k)	£227.5k	£222.5k	£217.5k
Median total remuneration	£28,346	£25,512	£25,934
Ratio	8.07	8.82	8.48

Notes on Table 3 : The HM Treasury Financial Reporting Manual (FReM), requires the Trust to disclose the median remuneration of Trust staff, and the ratio between this and the mid-point of the banded remuneration of the highest paid director. This calculation is based on full-time equivalent staff of the Trust at 31 March 2021 on an annualised basis.

Table 3 subject to audit

Remuneration Report signed by the Chief Executive

Kirsten Major

Chief Executive

11 June 2021

Staff Report

The colleagues and volunteers of Sheffield Teaching Hospitals NHS Foundation Trust are the reason for our continued success and have been vital to the Trust's response to the Covid-19 pandemic. Our 18,000 plus workforce is vital to ensuring we continue to deliver high quality care, and over the last year they have shown immense flexibility, dedication, and commitment to work above and beyond the requirements of their individual roles to care for and support our patients. Without them we would not be able to deliver the standard of care, or offer the range of clinical services, that we do.

Through continued commitment to deliver our People Strategy, we are dedicated to ensuring that Sheffield Teaching Hospitals is a brilliant and personal place for our colleagues to work. Focused on 10 workstreams, this strategy allows us to provide our colleagues with the best opportunities to put patients first.

We have continued to work with our PROUD values and to embed these into the Trust's ethos.

The PROUD values are:

- Patient first - Ensure that the people we serve are at the heart of all we do
- Respectful - Be kind, respectful to everyone and value diversity
- Ownership - Celebrate our successes, learn continuously and ensure we improve
- Unity - Work in partnership and value the roles of others
- Deliver - Be efficient, effective and accountable for our actions

Our PROUD values and behaviours underpin the way in which we all work and deliver the best service at all times. We strive to achieve exceptional engagement and leadership, ultimately delivering the best for our patients.

This year we have refreshed our strategy against the NHS People plan and have reviewed and prioritised our work to align with the demands of the pandemic across all implementation work streams.

We continue to recognise the great work that individuals and teams carry out via our annual Thank You Awards, our Long Service Awards and at local department level. This year, in recognition of the hard work during the pandemic, the Board of Directors have awarded an additional thank you gesture of £100 which was much appreciated by colleagues.

We have continued to expand our reward programme for colleagues, which includes many salary sacrifice options and staff discounts. In November 2020 we were proud to be winners at the national Employee Benefits Awards for the Best Voluntary Benefits, an award which is open to all sectors.

Working with our staff

Statement on approach to staff engagement

We recognise that in order to deliver consistently high quality clinical services it is important to have colleagues who feel valued and cared for and who are willing to go over and above.

The Trust is committed to involving colleagues in decision-making, engaging them on key developments and keeping them informed of change across the organisation.

We use a range of well-established communications channels to ensure that all colleagues are aware of both internal and external developments that may affect the Trust. These include a regular briefing from the Chief Executive which this year continued online and a weekly email bulletin to all colleagues, as well as using our social media feeds. Our intranet pages provide access for colleagues to Trust policies, guidance and online resources. A specific Covid-19 section was created on the intranet.

The Trust has a well-established Partnership Forum where management and union representatives meet to discuss Trust-wide workforce issues. Through this forum, policies and procedures are formally agreed and wider views sought on a broad range of subjects that may affect colleagues, including formal consultation on areas of organisational change.

We recently received the results of our 2020 Staff Survey and are actively reviewing this feedback to identify themes that we can address with our colleagues to improve their experience at work. More detail is included later in this report and our full survey results are available electronically from the following link.

The Trust's Freedom to Speak Up Guardian, supported by the Freedom to Speak Up Steering Group, has focused on expanding our support infrastructure for employees wishing to raise concerns.

The Trust currently has one Freedom to Speak Up Guardian supported by a number of Freedom to Speak Up Advocates from across the organisation. Their contact details can be found on the Human Resources intranet page and are publicised on posters across the organisation. A further two Guardians have been appointed from the new Staff Governors. They will take up the role of Guardian once they have attended the national training provided to support them in this role.

Regular communication bulletins, including profiles of Guardians and Advocates, have been issued to increase awareness of these roles across the Trust.

This year due to the pandemic the staff Friends and Family test was put on hold but we have found other ways of seeking colleagues' feedback through online forums such as the PROUD forum and Chief Executive webinars. In April we will also be introducing the quarterly NHSI People Pulse check.

National Staff Survey

Each year the Trust undertakes a census survey as part of the National Staff Survey. This annual survey provides invaluable information to ensure that the views of colleagues are heard and appropriate responses to feedback are given.

The Trust is benchmarked in the acute and acute and community trusts group.

Fig: Response rate to the NHS Staff Survey: Staff involvement

2020		2019	
Trust	National Average	Trust	National Average
42%	Not yet available – benchmarking group average 45%	45%	46%

The benchmarked findings of the 2020 survey are presented across a number of theme scores (scored out of 10) as outlined in the following table.

Fig: 2020 Staff survey results

	2020		2019		2018	
	Trust	Benchmark group	Trust	Benchmark group	Trust	Benchmark group
Equality, diversity and inclusion	9.3	9.1	9.2	9.2	9.3	9.2
Health and wellbeing	6.1	6.1	6.0	6.0	5.9	5.9
Immediate managers	6.9	6.8	6.9	6.9	6.8	6.8
Morale	6.4	6.2	6.3	6.2	6.3	6.2
Quality of care	7.5	7.5	7.4	7.5	7.4	7.4
Safe environment – bullying and harassment	8.5	8.1	8.4	8.2	8.4	8.1
Safe environment – violence	9.5	9.5	9.5	9.5	9.5	9.5
Safety culture	6.9	6.8	6.9	6.8	6.8	6.7
Staff engagement	7.0	7.0	7.1	7.1	7.0	7.0
Team working	6.3	6.5	6.5	6.7	6.5	6.6

Of the 10 themes in the 2020 benchmarked report five scored above average for our benchmarking group of acute and acute and community trusts. These are:

- Equality, diversity and inclusion
- Immediate managers
- Morale
- Safe environment – bullying and harassment
- Safety culture

A further four scores were average:

- Health and wellbeing
- Quality of care
- Safe environment – violence
- Staff engagement

Only one theme scored below average:

- Team working

There has been little significant change in theme scores since last year. The only statistically significant changes are an improvement in the Health and wellbeing score theme and deterioration in the Team working theme.

The highest score overall was achieved in Safe environment – violence (9.5) and the lowest Health and wellbeing (6.1) albeit this was still average for our benchmarking group. STH is close to the best in the benchmarking group for both the Equality, diversity and inclusion and Safe environment - bullying and harassment score.

It was particularly pleasing to note in the survey that the percentage of colleagues recommending the Trust as a place to work increased for the sixth year running to 71 per cent (well above the average of 66.9 per cent). The percentage of colleagues recommending the Trust as a place for treatment has improved also to 84 per cent, well above the average (74.3 per cent).

The Staff Survey results will be used to update the directorate action plans and, at a Trust level, the implementation of the 10 themes of the People Strategy continues. Together, these will improve colleagues' experience.

Equality, Diversity and Inclusion

The Trust aims to create a diverse and inclusive workforce that attracts and engages talented individuals from all backgrounds. We will celebrate diversity and promote a culture of inclusion.

Our vision is to have a workforce that fully reflects the communities we serve and a workplace culture in which everyone feels valued and is treated with fairness and respect.

We are achieving our vision by:

- Developing robust ways to manage performance and ensuring that all areas embed equality, diversity and inclusion (EDI) best practice.
- Ensuring there is visible leadership of EDI, that people are leading by example and that we achieve what we say we will within the deadlines agreed.
- Building strong community connections and networks so that our activity is informed by conversations with local people and partners.
- Embedding a zero tolerance approach to any form of discrimination, bullying, harassment and victimisation and bringing people together to create a social movement for change.
- Building the EDI capability of every member of staff so that we are all confident to challenge when we witness language or behaviour that doesn't fit with the Trust's PROUD values.
- Using positive action to build a diverse workforce, ensuring access to opportunities for current colleagues, supporting our staff network groups and ensuring that we support our disabled colleagues with reasonable adjustments.
- Embedding an effective way of measuring and evaluating what we are achieving and what impact we are having across the organisation.

As well as EDI being a 'golden thread' throughout our People Strategy, we have a specific workstream entitled 'Promoting and valuing difference'. This workstream is leading the programme of work to achieve our vision which is overseen by our Equality, Diversity and Inclusion (EDI) Board. The Board provides oversight to, and governance of, the Trust's strategic approach to meeting its legislative, moral and social duties, including those within the Equality Act 2010, the Human Rights Act 1998, the NHS Equality Delivery System and the national NHS Workplace Race and Disability Equality Standards.

With a diverse and broad membership, including senior leaders, the Board reports to the Trust Executive Group and oversees any EDI work carried out in respect of workforce, patients and service delivery.

Over the past 12 months, we have made significant progress on EDI through a collaborative approach working across the whole Trust and with our partners and communities. Some of our achievements are listed below:

- Establishment of our EDI Team, with a Head of EDI and two EDI Manager posts being created.
- Development of our new EDI Strategy that clearly communicates our key priority areas and the action we plan to take.
- Supporting our staff network groups to develop and grow.
- Achieving an overall improvement in our Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) performance. Establishing realistic but challenging action plans.
- Developing a Diversity and Inclusion Calendar and agreeing key dates to be marked by the Trust on an annual basis.
- Establishing a Reciprocal Mentoring Programme where senior leaders and staff network group members are paired to share experiences and support each other.
- Launched our representative recruitment panels approach to ensure ethnicity and gender representation throughout the recruitment process.
- Developed a Race Equality Charter as part of our partnership working with the Sheffield Accountable Care Partnership, in response to the Covid-19 pandemic and its spotlight on race inequality.
- Launched a new rapid equality impact assessment process with guidance and training to ensure we fully understand the implications of what we propose and do.
- Developed an EDI performance dashboard with key indicators covering patient, staff and operational EDI.
- Supported our colleagues and protected them from harm through the Covid-19 pandemic by developing and implementing the Individual Staff Impact Assessment process.
- Commitment to the development of a personalised programme of training for our Board of Directors and Governors.
- Developed and delivered Trans and Gender Diversity training to challenge myths and misconceptions and promote a culture of inclusion and respect.
- Procured a series of e-learning resources to increase the capability and confidence of colleagues in terms of EDI.

Further information about the Trust's EDI objectives can be found on our website at via this link.

Staff health and safety and incident management

The Trust has in place robust health and safety management systems to ensure that risks to health and safety are identified, evaluated and controlled to minimise harm. Covid-19 has meant that our health and safety focus this year has been on the management and control of infection to our staff, not only from patients but also their colleagues.

Assessments of the risks to our colleagues from Covid-19 have been carried out, especially for those who are deemed clinically extremely vulnerable. Assessments have also been carried out on our work environments, both clinical and non-clinical. Together, these have resulted in changes to the way our colleagues are now working. Implementing and following national guidance has required a co-ordinated and team response to the issues. This has been achieved through setting up subject expert groups with colleagues from a range of disciplines to enable an inclusive approach to managing the risks identified.

Additional control measures have been put in place, on top of our normal processes and protections, including personal protective equipment (PPE) for all colleagues, enhanced infection control systems, social distancing measures and working from home.

Members of our staff have been among those who have tested positive for Covid-19. We have established a process involving Occupational Health to review those cases where potential exposure occurred to identify any learning to improve the safety for our colleagues and meet our duties under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.

The work during the pandemic builds on our governance processes in place for reporting incidents. The table below shows the number of incidents reported over the last three years involving colleagues (including bank / agency), members of the public, students and contractors. In addition to monitoring incident data centrally, it is monitored at directorate level via formal governance management processes.

Fig: Total number of incidents by work group

Total number of incidents by work group	2020/2021	2019/2020	2018/2019
Accident / Incident involving contractor	39	44	30
Accident / Incident affecting member of public	184	278	238
Accident / Incident involving student	25	52	60
Accident / Incident involving member of staff	1799	2097	1742
Total number of accidents / incidents	2047	2471	2070

Board oversight of staff health and safety is via a bi-monthly Safety and Risk Committee chaired by the Medical Director and an annual report to the Healthcare Governance Committee.

Staff health and wellbeing

The Trust had a well-established Employee Assistance Programme provided by Vivup, prior to the pandemic which has continued to be available 24 hours a day, seven days a week to provide colleagues with support whenever they need it. Vivup also provides a range of self-help Cognitive Behavioural Therapy (CBT) guides, an App to help manage stress and podcasts to support colleagues with their wellbeing.

We acted quickly to introduce Covid-19 testing for all colleagues and their families and this was supported by the rapid introduction of a Covid-19 Absence Reporting System which provided a daily picture of Covid-19 absence and the impact on service, and allowed the Trust to support colleagues to return to work quickly following either a negative test or the end of their isolation period. We introduced risk assessments (QRISK3) to identify and support those colleagues most at risk of Covid-19. All colleagues were offered an individual Covid-19 impact assessment. Colleagues who have been required to shield during the year have received supportive contact from their managers, have been supported to work from home wherever possible and have received risk assessments to support a safe return to work in August of last year, prior to shielding recommencing. Many of our colleagues continue to work from home and the Trust developed and implemented a Home Working Policy which provides guidance for managers and colleagues and incorporates a risk assessment of the homeworking environment.

We have now also undertaken a programme of Covid-19 vaccinations for all front line colleagues as well as the annual flu vaccinations programme.

In addition, this year a national NHS wellbeing offer has been introduced which many of our colleagues have been able to access, including listening lines, bereavement support and access to a range of free apps for anxiety, mindfulness, sleep and exercise, and including culturally appropriate ones. Through the NHS People Plan, colleagues have also been able to access peer support via leadership circles which the Organisational Development Department now run within the Trust.

Thanks to the support of Sheffield Hospital Charity, we have been able to increase the wellbeing support during the last year to include:

- Establishing 45 calm rooms across the Trust to provide a quiet space for staff to rest and reflect.
- Increased psychological support for teams in addition to some support provided by colleagues in the Department of Psychological Services which was much appreciated during the first wave of the pandemic.
- Increased training in mental health first aid.
- Wellbeing grants for departments / teams to support the provision of refreshments.

During 2021 there will also be increased support available for colleagues via the South Yorkshire and Bassetlaw Wellbeing Hub.

We have also continued to provide access to the staff physiotherapy service and encouraged colleagues to keep active through the introduction of an online fitness platform. This was particularly important for colleagues working at home.

Countering fraud and corruption

The Trust does not tolerate any form of fraud, bribery or corruption by, or of, its employees, associates or any person or body acting on its behalf. Maintaining fraud levels at an absolute minimum ensures that more funds are available for patient care and services.

The Trust engages 360 Assurance as its Local Counter Fraud Specialist (LCFS) to support the Board of Directors' commitment to maintaining an honest and open culture, ensuring that all concerns involving potential fraud have been identified and rigorously investigated. In all cases appropriate civil, disciplinary and / or criminal sanctions have been applied, where guilt has been proven. This supports the embedding of deterrence and prevention measures across the organisation.

The Trust's Audit Committee agrees the annual work plan for the LCFS and receives routine reports on progress against its delivery. The Committee has agreed the Trust's policy for dealing with suspected fraud, bribery and corruption and the Trust's Standards of Business Conduct Policy.

Staff analysis

Staff numbers

Fig: Average number of persons employed (contracted whole time equivalent basis)

	2020/21			2019/20		
	Permanent	Other	Total	Permanent	Other	Total
Medical and Dental staff	1,940	36	1,976	1,830	54	1,884
Administration and Estates staff	3,142	65	3,207	3,080	38	3,117
Healthcare Assistants and other Support staff	1,645	232	1,877	1,617	260	1,877
Nursing, Midwifery and Health Visiting staff	5,936	110	6,046	5,706	134	5,840
Scientific, Therapeutic and Technical staff	2,684	16	2,700	2,630	18	2,649
Healthcare Science staff	151	-	151	148	-	148
Total average numbers	15,498	459	15,957	15,011	504	15,516

Figure subject to audit

Staff Turnover

Data for staff turnover at the Trust is published by NHS Digital within NHS Workforce Statistics and can be accessed via the following link.

Gender of staff

On 31 March 2021, the Trust Board of Directors had 15 voting members, 9 male and 6 female. Women represent 64.6 per cent of senior staff at band 8 and above.

The current Trust headcount at 31 March 2021 was 18,079. Female employees comprised 76.6 per cent of the workforce and 23.4 per cent were male.

It became mandatory for public sector organisations with over 250 employees to report annually on their Gender Pay Gap. Analysis for 2020 indicates that for our Trust there is an average hourly pay gap in favour of men of 21.3 per cent, which is a 0.4 per cent improvement on data for 2019 (21.7 per cent). This pay gap is largely accounted for by a combination of a higher proportion of female colleagues in bands 1-4, and higher numbers of male colleagues in senior medical (consultant) posts.

High level actions in place to address this gap include:

- Continue to deliver on our People Strategy which prioritises equality, diversity and inclusion.
- Supporting the career path of women in medicine, through work such as the SuppoRTT programme which provides funding to medical and dental employees returning from long periods of absence, such as those returning to work from caring responsibilities
- Further developing existing links with Sheffield Women in Medicine (SWIM) which a number of our female medical and dental colleagues support. In addition we are establishing a Trust Women's Staff Network Group with the aim that this will be in place during summer 2021.
- Work on attracting and recruiting men into the organisation particularly focused on Agenda for Change pay bands 1 to 4 (Facilities roles) to create a more gender balanced workforce.
- Promotion of the wide breadth of career opportunities available across all roles and professions within the Trust / NHS through our role as an anchor institution working with schools.
- Raise awareness of shared parental leave entitlements and flexible working opportunities for all, including review and refresh of our Flexible Working Policy.
- Continue to provide career development opportunities for all colleagues, including mentoring and coaching and continued development of our leadership and management development programme (LEAD).

Information on Trust information on the gender pay gap can be found on the Cabinet Office website.

Staff sickness absence data

Data for average sick days per full time equivalent (FTE) provided by the Department of Health and Social Care is published by NHS Digital can be accessed here.

Staff costs

Fig: Analysis of staff costs

	2020/21 Permanent £000	Other £000	Total £000	2019/20 Total £000
Salaries and wages	601,957	20,190	622,147	569,542
Social security costs	53,472	-	53,472	49,464
Apprenticeship levy	2,852	-	2,852	2,669
Employer's contributions to NHS Pensions Scheme	100,295	-	100,295	93,829
Pension cost – others	405	-	405	400
Agency / contract staff	-	7,188	7,188	11,248
Total	**758,981**	**27,378**	**786,359**	**727,152**

Note: The above figure of £786,359k is net of the amount of £926k (2019/20 £1,071k) in respect of capitalised salary costs included in fixed asset additions (notes 8.1 and 9.1 to the accounts).

Figure subject to audit

Exit packages

The table below summarises the total number of exit packages agreed during the year.

Fig: Compensation scheme - exit packages

Staff exit packages	2020/21			2019/20		
Exit package cost band (including any special payment element)	Compulsory redundancies	Other departures agreed	Total exit packages	Compulsory redundancies	Other departures agreed	Total exit packages
< £10,000	0	0	0	0	0	0
£10,001 - £25,000	0	0	0	0	0	0
£25,001 - £50,000	0	0	0	1	0	1
£50,001 - £100,000	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0
Total number by type	0	0	0	1	0	1
Total resource cost (£000)	0	0	0	45	0	45

Notes: Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Pension Scheme. Exit costs in this table are the full costs of departures agreed in the year. Where Sheffield Teaching Hospitals NHS Foundation Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

There were no non-compulsory departures / departure payments in either 2020/21 or 2019/20.

Figure subject to audit

Trade union facility time

The Trade Union (Facility Time Publication Requirements) Regulations 2017 came into force on 1 April 2017. These regulations require public sector employers to collate and publish, on an annual basis, a range of data on the amount and cost of trade union facility time within their organisation.

Fig: Relevant union officials

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
58	51.79

Fig: Percentage of time spent on facility time

Percentage of time	Number of employees
0%	50
1 - 50%	4
51 - 99%	0
100%	4

Fig: Percentage of total pay bill spent on facility time

Percentage of total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.	Figures
Total cost of facility time	£108,263.09
Total pay bill	£786,359,000
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.014%

Fig: Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: 808.22 hours / 6444.98 hours	Per cent
Total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	12.54%

Off payroll engagements

The Trust has identified eight off-payroll engagements remunerated at more than £245 per day which have lasted for between one and five years during 2020/21.

In addition, a further 32 engagements have been identified which are new for 2020/21. Of these new engagements, all were assessed as within the scope of IR35. In all cases, assurances/appropriate actions have been taken to ensure the appropriate declaration of income tax and national insurance are made to HMRC.

A total of 19 individuals have been deemed Board members and / or senior officials with significant financial responsibility during 2020/21, all of which were on-payroll engagements.

Table 1: For all off-payroll engagements as of 31 March 2021, for more than £245 per day and that last for longer than six months

Number of existing engagements as of 31 March 2021	40
Of which	
Number that have existed for less than one year at time of reporting	32
Number that have existed for between one year and two years at time of reporting	7
Number that have existed for between two years and three years at time of reporting	0
Number that have existed for between three years and four years at time of reporting	1
Number that have existed for between for four or more years at time of reporting	0

Table 2: All highly-paid off-payroll workers engaged at any point during the year ended 31 March 2021 earning £245 per day or greater

Number of off-payroll workers engaged during the year ended 31 March 2021	40
Of which	
Not subject to off-payroll legislation *	0
Subject to off-payroll legislation and determined as in-scope of IR35 *	40
Subject to off-payroll legislation and determined as out-of-scope of IR35 *	0
Number of engagements reassessed for compliance or assurance purposes during the year	8
Of which: number of engagements that saw a change to IR35 status following review	0

* A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Trust must undertake an assessment to determine whether that worker is in scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes

Table 3: For all off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2020 and 31 March 2021

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed board members and/or senior officials with significant financial responsibility during the financial year. This figure must include both off-payroll and on-payroll engagements	19

Code of Governance Report

Our Council of Governors

The Council of Governors advises the Trust on how best to meet the needs of patients and the wider community we serve. It has a number of statutory duties, including holding the Non-Executive Directors to account for the performance of the Board of Directors and representing the interests of Trust Members and members of the public.

The Council of Governors works with the Board of Directors to shape the Trust's future strategy and is responsible for providing feedback from the Membership and stakeholders on proposed strategic developments. The Trust keeps the Council of Governors fully informed on all aspects of the Trust's performance through formal council meetings.

Comprised of elected and nominated Governors, as detailed below, the Council of Governors has decision-making powers defined by statute. These powers are outlined in the Trust's constitution and principally refer to the appointment, removal and remuneration of the Trust Chair and Non-Executive Directors; the appointment and removal of the Trust's external auditors; the approval of the appointment of the Chief Executive; and receiving the Trust's annual accounts, any report of the auditor on the accounts and the Annual Report.

While the Council of Governors is responsible for holding the Board, and in particular, the Non-Executive Directors, to account and ensuring that it is acting in a way that means that the Trust will meet its obligations, it continues to remain the responsibility of the Board of Directors to oversee the running of the Trust.

The Council of Governors discharges its statutory responsibilities through a combination of formal Council meetings, standing committees and working groups.

During 2020/21 arrangements were put in place to ensure that members of the Council of Governors remained informed and engaged in Trust business during Covid-19 social distancing restrictions, and in line with provisions within the Standing Orders of the Council of Governors, the Council was able to conduct all its business by video conferencing.

A record of attendance by individual Governors at formal meetings of the Council of Governors is presented in the following tables. These tables outline membership of the Council of Governors during 2020/21.

Composition of the Council of Governors 2020/21

As at 31 March 2021 there were 33 seats on the Council of Governors: 13 to represent public Members, seven to represent patients, six to represent staff Members and seven seats for Governors nominated by partner organisations. There are three vacant seats on the Council of Governors for nominated partner governors.

Fig: Council of Governors membership and attendance 2020/21

	Elected / Re-elected from	Attendance (actual / possible)
Patient Governors		
Barbara Bell (to 31 October 2021)	1 July 2017	3 from 3
George Chia	1 July 2018	4 from 5
David Foster	1 July 2019	4 from 5
Steve Jones	1 November 2020	5 from 5
Kath Parker	1 July 2018	5 from 5
Harold Sharpe	1 December 2019	3 from 5
Shirley Sherwood	1 November 2020	2 from 2
Fiona Tatton	1 July 2019	1 from 5
Public Governors		
Mick Ashman	1 July 2019	2 from 5
Steve Banks	1 July 2019	5 from 5
Georgina Bishop	1 November 2020	1 from 2
Wendy Bradley (to 30 June 2020)	1 July 2017	2 from 2
Michelle Cook (to 31 October 2020)	1 July 2017	3 from 3
Sally Craig (to 31 October 2020)	1 July 2017	3 from 3
Martin Hodgson	1 July 2019	4 from 5
Joyce Justice	1 July 2018	3 from 5
Kaye Meegan	1 November 2020	2 from 2
Ian Merriman	1 July 2018	5 from 5
Brendan Molloy	1 July 2018	5 from 5
Lewis Noble	1 July 2018	3 from 5
Jane Pratt	1 November 2020	2 from 2
Sheila Reynolds	1 November 2020	1 from 2
Joe Saverimoutou	1 July 2018	5 from 5
Chris Sterry	1 July 2019	3 from 5
Sue Taylor	1 July 2019	4 from 5

Staff Governors		
Paulette Afflick-Anderson	1 November 2020	1 from 2
Irene Mabbott	1 July 2018	3 from 5
Liz Puddy	1 November 2020	1 from 2
Cressida Ridge	1 November 2020	2 from 5
Karen Smith	1 July 2017	2 from 3
Pete Tanker	1 July 2018	2 from 5
Appointed Governors	**Appointed**	
Amanda Forrest. Sheffield CCG (to 31 December 2020)	21 April 2015	3 from 4
Angela Foulkes, Sheffield College	10 December 2018	3 from 5
Tim Furness, Voluntary Action Sheffield	1 February 2018	4 from 5
Luc de Witte, University of Sheffield	1 November 2017	4 from 5
David Warwicker, Sheffield CCG	30 March 2020	1 from 1

Attendance is recorded for the four Council of Governors meetings held by video-conference during 2020/21 (30 June 2020, 29 September 2020, 15 December 2020 and 30 March 2021). Additionally, an extraordinary meeting was held by these same means on 28 May 2020. This meeting provided a forum for the Board of Directors to apprise Governors of the Trust's emergency planning response to Covid-19 and to consider routine Council business following cancellation of a face-to-face meeting scheduled for 31 March 2020, in line with Covid-19 restrictions.

Governors are required to declare interests which are relevant and material to the business of the Trust.

The Council of Governors' Nomination and Remuneration Committee

The Nomination and Remuneration Committee of the Council of Governors makes recommendations to the Council on the appointment and remuneration of the Chair and Non-Executive Directors and considers and contributes to their appraisals.

At an extraordinary meeting of the Council of Governors held on 13 November 2020 the Council of Governors approved the Committee's recommendation to appoint Annette Laban as Trust Chair. This followed a recruitment and nomination process led by the Committee.

The Nomination and Remuneration Committee was also convened during the latter part of 2020/21 to commence the process to recruit a Non-Executive Director to fill the vacancy on the Board of Directors following the appointment of former Non-Executive Director Annette Laban as Trust Chair. The outcome of this recruitment process allowed a recommendation to be made to the full Council of Governors in

April 2021 to appoint Maggie Porteous as a Non-Executive Director for a four year term of office from 1 May 2021.

At this same extraordinary Council meeting in April 2021 the Council of Governors approved a second Non-Executive appointment. This followed approval of a recommendation to recruit to an additional Non-Executive Director position on the Board of Directors to correct the balance of independence on the Board of Directors following an increase in the Executive composition of the Board of Directors and to appoint to this position through a nomination by Sheffield Hallam University.

Dr Toni Schwarz, nominated by Sheffield Hallam University, will take up a four year term of office from 1 May 2021.

Remuneration of Non-Executive Directors and the Chair

The Council of Governors did not change the amount of remuneration paid to the Non-Executive Directors or the Chairman during 2020/21.

In giving in-year consideration to the advertisement of the position of Trust Chair and of a Non-Executive Director vacancy, the Nomination and Remuneration Committee of the Council of Governors considered levels of Non-Executive Director remuneration using national benchmarking data.

Elections held within the reporting period

In line with national guidance issued by NHSE/I regarding holding Governor Elections during the NHS response to the Covid-19 pandemic, the Trust decided to temporarily postpone elections scheduled to take place between May and June 2020. This was ratified at an extraordinary meeting of the Council of Governors held in May 2020.

Interim arrangements were agreed to allow current Governors with terms of office due to expire on 30 June 2020 to remain engaged in Governor matters, including meetings of the Council of Governors, until these elections could be rescheduled later in the year.

These Council of Governor elections took place between July and October 2020 with the results declared on 8 October 2020. Nominations were sought for 10 seats across eight constituencies.

Twenty nominations were received from members who wished to stand for election, including six current Governors seeking reappointment.

Six constituencies were contested: South West Sheffield (public), Sheffield North (public), the patient constituency and staff constituencies of allied health professions, scientists and technicians, management, administrative and clerical staff and medical and dental staff.

All elections are held in accordance with the election rules set out in our constitution. Turnout in the contested seats was as follows:

- South West Sheffield (Public) - 20 per cent
- North Sheffield (Public) – 11.8 per cent
- Patients – 17. 8 per cent
- Allied Health Professionals, Scientists & Technicians (Staff) – 15.2 per cent
- Management, Admin & Clerical (Staff) – 22.7 per cent
- Medical & Dental (Staff) – 21.7 per cent

Eight new Governors and two reappointed Governors started their terms of office on 1 November 2020.

In the event of an elected Governor's seat falling vacant for any reason before the end of a term of office it shall be filled by the second placed candidate in the last election held for that seat.

Lead Governor

In line with the Foundation Trust Code of Governance, the Council of Governors elects one of the Public Governors to be Lead Governor. This is to act as the main point of contact for NHS Improvement (NHSI) should the regulator wish to contact the Council of Governors on an issue for which the normal channels of communication are not appropriate.

In 2017 a formal nomination process for the position of Lead Governor was held, through which Patient Governor, Kath Parker, was appointed as Lead Governor.

Strengthening links between the Board and Governors and Members

The Board of Directors is committed to working collaboratively with the Council of Governors. Executive and Non-Executive Directors value the role and contribution of Governors and work openly and transparently with the Council.

Although not members of the Council of Governors, Directors attend Council meetings and listen and respond to Governors' views. The Chair of the Board of Directors also chairs the Council of Governors, providing a link between the two.

To strengthen the relationship further, the Chair and Non-Executive Directors are invited to attend the quarterly Governors' Forum meetings.

Governors observe the Board of Directors' meetings held in public and are invited to meet monthly with the Chair to review and discuss items debated by the Board in its private session. Governors are invited to observe committees of the Board of Directors to support them in fulfilling their statutory duty of holding the Board of Directors to account and assist in their assessment of the performance of Non-Executive Directors.

Directors also attended the Annual Members' Meeting which was held virtually on 21 September 2020.

Fig: Attendance by Directors at Council of Governors meetings

Name		Attendance (actual / possible)
Tony Pedder	Chair until 31 December 2020	4 from 4
Annette Laban	Chair from 1 January 2021	5 from 5
Tony Buckham	Non-Executive Director (Vice Chair)	4 from 5
Paul Buckley	Interim Director of Strategy and Planning (from September 2020)	4 from 4
Anne Gibbs[a]	Director of Strategy and Planning	1 from 1
Mark Gwilliam	Director of HR and Staff Development	5 from 5
Michael Harper	Chief Operating Officer	5 from 5
Jennifer Hill	Medical Director (Operations)	4 from 5
David Hughes	Medical Director (Development)	5 from 5
Kirsten Major	Chief Executive	5 from 5
Chris Morley	Chief Nurse	4 from 5
Chris Newman	Non-Executive Director	0 from 5
Neil Priestley	Director of Finance	4 from 5
John O' Kane	Non-Executive Director	2 from 5
Rosamond Roughton[b]	Non-Executive Director	3 from 3
Martin Temple	Non-Executive Director	4 from 5
Shiella Wright	Non-Executive Director	5 from 5

[a] Long term absence precluded attendance at Council of Governors meetings
[b] For a short period of two months during 2020/21 (May and June) Rosamond Roughton formally stepped back from her duties as a Non-Executive Director (NED) due to pressures related to Covid-19 impacting on her role with the Department of Health and Social Care.

There has also been continued focus on involving the Council of Governors in key developments and issues impacting the Trust. Governors attend monthly Governors' Board Briefing meetings, quarterly finance briefings and bi-annual updates from the Director of Human Resources and Staff Development.

Individual Governors attend a range of Trust Committees including:

- Patient Experience Committee
- Infection, Prevention and Control Committee
- Mental Health Committee
- Psychology Board
- Patient-Led Assessments of the Care Environment (PLACE)
- Travel and Transport Strategy Group
- Clinical Effectiveness Committee
- Equality, Diversity and Inclusion (EDI) Board
- End of Life Care Group
- PROUD Forum
- Food Management Group
- Emergency Planning Operational Group
- Pharmacy Board
- Nutrition Steering Group

During the Covid-19 pandemic, presentations for Governors from staff regarding Trust services and Governors' visits to departments around the Trust have been paused.

Membership

The Trust considers its Membership to be a valuable asset, which helps guide its work and the decisions it makes, while also holding the organisation to account and ensuring we adhere to NHS values. It is one of the ways the Trust communicates with patients, the public and staff.

The Trust has four Membership categories:

- Patients: anyone aged 12 years or over who has been a patient of the Trust
- Public: residents of Sheffield 12 years or over
- Public Outside Sheffield: residents of England and Wales, outside Sheffield, aged 12 years or over
- Staff: employees contracted to work for the Trust for at least one year

The Trust recognises the value and importance of a broad engagement strategy and has set up an Engagement Network to enhance its existing patient and public feedback activities, seeking to create new opportunities for local people to have a say about the Trust's services, get involved in research and innovation, become volunteers and consider standing for election as a Governor. Young people are also encouraged to join the Trust's Youth Forum.

The Engagement Network is linking with local community groups / organisations, Governors and Foundation Trust Members. By liaising with existing groups and networks it is envisaged that it will grow to represent all the communities that the Trust serves.

As in previous years, all Members were invited to our Annual Members' Meeting (AMM). Due to Covid-19 social distancing requirements this was held virtually.

Fig: Membership breakdown at 31 March 2021

Constituency	Sub-constituency	Number of members
Patient Membership		**3,425**
Public Membership	North Sheffield	1,981
	Sheffield South East	2,191
	Sheffield South West	1,882
	West Sheffield	2,015
	Outside Sheffield	541
	Sub-total	**8,610**
Staff Membership	(sub divided into sub-constituencies listed)	**18,079**
	Medical and Dental	
	Nursing and Midwifery	
	Allied Health Professionals, Scientists and Technicians	
	Administration, Management and Clerical	
	Ancillary, Works and Maintenance Staff	
	Primary and Community Services Staff	
	Grand total	**30,114**

Meetings of the Board of Directors and its committees

The Board of Directors is the decision-making body for strategic direction and the overall allocation of resources. It delegates decision making for the operational running of the Trust to the Trust Executive Group. The Board takes decisions consistent with the approved strategy.

The Board's role is to promote the success of the organisation so as to maximise the benefits for the Members of the Trust as a whole and for the public. It does this by:

- ensuring compliance with its licence, its constitution and statutory, regulatory and contractual obligations
- setting the strategic direction within the context of NHS priorities which provides the basis for overall strategy, planning and other decisions
- monitoring performance against objectives
- providing robust financial stewardship to ensure the Trust functions effectively, efficiently and economically
- ensuring the quality and safety of healthcare services, education and training and research
- applying best practice standards of corporate governance and personal conduct
- promoting effective dialogue between the Trust and the local communities we serve

The Board delegates decision-making for the operational running of the Trust to the Trust Executive Group in accordance with the Trust's Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions.

The Trust's Standing Orders set out matters which are reserved for the Board of Directors to decide. These relate to regulation and control, appointments, strategic and business planning and policy development, direct operational decisions, financial and performance reporting arrangements, audit arrangements and investment decisions. During 2020/21 Board of Directors' meetings have been scheduled monthly, with the exception of the month of August. Meetings are held in public, although part of the meeting is held in private to deal with matters of a confidential nature. The agenda and papers for the section of the meeting held in public are published on the Trust's website.

In light of Covid-19 social distancing requirements in place throughout 2020/21, the Board of Directors has held its meetings virtually. To maintain transparency and accountability to the public during this period, the Board has invited members of the Council of Governors, as representatives of our Foundation Trust membership and our partner organisations, to observe these virtual meetings via video link or voice only conference. Papers for the public Board meeting have continued to be published on the Trust's website. The Board of Directors looks forward to welcoming

back members of the public to its meetings as soon as the necessary steps to limit the transmission of Covid-19 are lifted.

Membership of the Board of Directors is detailed on pages 27 to 31 of this report. The following table presents the attendance records of individuals at Board meetings held during 2021/22.

Fig: Attendance by Board of Directors meetings

Name		Attendance (actual / possible)
Tony Pedder	Chair, until December 2020	8 from 8
Annette Laban	Chair, from January 2021	11 from 11
Tony Buckham	Non-Executive Director (Vice Chair)	11 from 11
Paul Buckley	Interim Director of Strategy and Planning (from September 2020)	7 from 7
Sandi Carman	Assistant Chief Executive	11 from 11
Anne Gibbs[a]	Director of Strategy and Planning	3 from 4
Mark Gwilliam	Director of Human Resources and Staff Development	11 from 11
Michael Harper	Chief Operating Officer	11 from 11
Jennifer Hill	Medical Director (Operations)	10 from 11
David Hughes	Medical Director (Development)	11 from 11
Kirsten Major	Chief Executive	11 from 11
Chris Morley	Chief Nurse	11 from 11
Chris Newman	Non-Executive Director	2 from 11
John O'Kane	Non-Executive Director	11 from 11
Julie Phelan	Communications and Marketing Director	11 from 11
Neil Priestley	Director of Finance	11 from 11
Rosamond Roughton[b]	Non-Executive Director	7 from 9
Martin Temple	Non-Executive Director	10 from 11
Shiella Wright	Non-Executive Director	10 from 11

[a] Long term absence precluded attendance at Board of Directors' meetings
[b] For a short period of two months during 2020/21 (May and June) Rosamond Roughton formally stepped back from her duties as a Non-Executive Director (NED) due to pressures related to Covid-19 impacting on her role with the Department of Health and Social Care.

The Board has established a committee structure with each of its standing committees chaired by a Non-Executive Director. This Board committee structure includes the statutory committees of Audit, Board of Directors' Nomination and Remuneration and Healthcare Governance, as well as Finance and Performance and Human Resources and Organisational Development.

More detail of the Board's committee structure and the role of its committees is outlined within the Annual Governance Statement.

Audit Committee

The Audit Committee is appointed by the Board of Directors and its terms of reference state that its membership comprises of four Non-Executive Directors. One of these members is required to have recent and relevant financial experience and this requirement is fulfilled through the Committee Chair, John O'Kane.

There is currently a vacancy on the Audit Committee following Annette Laban's appointment to the role of Trust Chair. This required Annette to step down from her position as Audit Committee member. This vacancy will be filled by a newly recruited Non-Executive Director.

Fig: Member attendance at meetings of the Audit Committee 2020/21

NED membership	Attendances (actual / possible)
John O'Kane, Chair	6 from 6
Annette Laban (until December 2020)	4 from 4
Chris Newman	2 from 6
Shiella Wright	6 from 6

Other Non-Executive Directors, who chair other Board committees, have a standing invitation to attend meetings of the Audit Committee.

Meetings of the Audit Committee are attended by senior representatives of the Trust's internal and external auditors, the local counter fraud specialist, as well as the Director of Finance and Assistant Chief Executive. The Chief Executive and the Trust Chair are invited to attend the meeting at which the annual accounts are presented.

The Committee provides the Board of Directors with an independent and objective review of the effectiveness of the system of internal control (both financial and non-financial). It is authorised by the Board of Directors to investigate any activity within its terms of reference and to seek information it requires from staff to fulfil its functions.

The Audit Committee is responsible for agreeing and reviewing the annual work plans for independent external and internal audit services, counter fraud services and commissioning independent audit work from other bodies as required.

The Trust's internal audit service is provided by 360 Assurance, a consortium principally serving a number of foundation trusts and clinical commissioning groups in the region. Through detailed testing of the Trust's internal control systems, this service fulfils a key role in the Trust's assurance processes.

Local counter fraud provision is commissioned from 360 Assurance. The local counter fraud specialist supports the Trust to create an anti-fraud culture, to deter,

prevent and detect fraud, investigating suspicions as they arise and seeking to apply appropriate sanction and redress in respect of any monies obtained through fraud.

The Audit Committee is responsible for making a recommendation to the Council of Governors in respect of the appointment and approval of the Trust's external auditors.

At its meeting held in September 2020, on the basis of a satisfactory evaluation of the external audit service received by the Trust, the Director Finance on behalf of the Audit Committee presented a recommendation to Governors that Mazars LLP be reappointed as the Trust's external auditors for the next audit cycle. This reappointment was confirmed by the Council of Governors and noted as the final year of the current contract which was originally awarded in September 2016 following a competitive tender exercise.

The statutory audit fee for the 2020/21 audit was £45,130 plus VAT.

The Committee routinely receives progress reports from Mazars LLP, including updates on key emerging issues / developments. Mazars LLP provides its services within the Code of Audit Practice. The Audit Committee has delegated authority from the Board of Directors to commission additional investigative and advisory services outside this code.

The provision of non-audit services by the external auditor would include any work relating to the assurance report on the Trust's annual Quality Report. On 15 January 2021, NHSE/I issued guidance confirming that, due to the Covid-19 pandemic, NHS foundation trusts are not required to commission assurance on their Quality Report for 2020/21.

In advance of the end of the external audit contract, the Committee met in March 2021, without Mazars LLP in attendance, as part of the competitive tender preparation for the external audit service. This work will be taken forward with involvement from Governors during the first part of 2021/22 to ensure that a contract award is made in advance of the 2021/22 audit cycle.

Principal areas of review and significant issues considered by the Audit Committee during 2020/21

The following section outlines key matters considered by the Committee, reflecting key duties / areas of responsibility set out by its terms of reference. Over the past 12 months there has been a need to expand the Committee's work plan to provide additional focus on the impact of the Covid-19 pandemic on the Trust's system of internal control. This has been reflected within agenda matters considered throughout the year and through the need to convene an extraordinary meeting of the Committee in April 2020 to specifically consider a number of governance matters relating to business continuity arrangements and the establishment of an emergency

planning command and control structure during the first wave of the Covid-19 pandemic.

Internal control and risk management

- Reviewing the Integrated Risk and Assurance Report (IRAR) on behalf of (October 2020 and March 2021) or in advance of presentation to the Board (January 2021) and overseeing the implementation of IRAR standard operating processes, incorporating a programme of deep-dive reviews through the Board committee structure.
- Receiving for discussion in March 2021 draft Principal Risks to be entered onto the 2020/21 IRAR; recalibrated based on the output of a thematic analysis of the Trust's current risk profile in light of the Covid-19 pandemic.
- Reviewing the annual financial statements, with particular focus given to major areas of judgement and any changes in accounting policies (January 2021) and the Board's determination that the 2020/21 annual accounts be prepared on a 'going concern' basis. This followed consideration of the planned financial position for 2021/22.
- Approving the Trust's refreshed Framework for Risk Management in July 2020.
- Receiving the Register of Interests Annual Report (July 2020).
- Discussing and agreeing proposals to undertake a review of the effectiveness of the Board and its committees (October 2020).
- Informed by its oversight of the Trust's systems of integrated governance, reviewing the adequacy of all risk and control related disclosure statements within the Trust's Annual Report (specifically, the Annual Governance Statement).

Specific focus on necessary strengthening of controls and assurances in the context of the impact of Covid-19

- At an extraordinary meeting of the Committee held in April 2020, noting the architecture established to identify, manage and oversee risks relating to Covid-19, the mapping of these onto IRAR Principal Risks and, as part of the operation of the IRAR, agreeing proposals for assurance to be provided through the Board committee structure.
- At this same extraordinary meeting, receiving discussion papers describing business continuity arrangements for Board assurance and governance during Covid-19 and the arrangements for responding to the Covid-19 level 4 major incident through establishment of a command and control structure.
- Receiving a paper for assurance setting out arrangements in place for accepting and recording gifts and donations offered in response to Covid-19 (April 2020).

- Supporting unscheduled review of the Trust's Risk Appetite Statement to give consideration to the need for any changes as the Covid-19 pandemic developed (July 2020).
- Reviewing arrangements for presenting the IRAR to the Board of Directors in July 2020 to build on discussion of Covid-19 command structure risks and their alignment with Principal Risks held at June meetings of Board committees.
- Noting retrospectively all Covid-19 personal protective equipment (PPE) orders in excess of the contract levels delegated within the Trust Reservation of Powers and Scheme of Delegation (June 2020).
- For assurance, noting generic procurement risks being managed on an on-going basis, and the additional controls introduced by the Trust in relation to the heightened procurement fraud risk in relation to PPE during the Covid-19 pandemic (June 2020).

Internal audit

- Agreeing at the start of the year the internal audit plan 2020/21, taking into account risk assessment work undertaken by 360 Assurance and with the Trust Executive Group, and informed by Public Sector Internal Audit Standards.
- Through the course of the year, routinely receiving findings from individual reviews within the internal audit work plan, including reviews focused on mobile working, integrity of the general ledger and financial reporting, decontamination contract management, absence data, use of electronic prescribing, data security standards and patient safety – serious incident/never event actions. Monitoring management's responsiveness to internal audit recommendations and providing oversight of follow up completion rates.
- In July 2020 approving changes to the internal audit plan 2020/21 to reflect the significant impact of the Covid-19 pandemic on the Trust's risk environment. The four reviews added to the plan were a review of a sample of the Covid-19 costs, a review of PPE ordering, receipting and payment, a review of the Trust's incident command structure and a review of absence data reporting during the pandemic.
- Receiving in May 2021 the Internal Audit Annual Report for 2020/21, including the Head of Internal Audit Opinion 2020/21, noting that the report found significant assurance on the Trust's system of internal controls.
- Undertaking annual review of the effectiveness of the internal audit function.

Local counter fraud

- Approving and overseeing progress against the annual fraud, bribery and corruption risk assessment and work plan through consideration of routine progress reports from the anti-crime specialist and receiving in May 2021 the Counter Fraud Annual Report 2020/21.

External audit

- Noting an agreed protocol for liaison between external audit and internal audit presented to the Committee in October 2020.
- Agreeing the 2020/21 Audit Strategy Memorandum (audit plan) in March 2021, setting out an analysis of the external auditor's assessment of significant audit risks, the proposed elements of the financial statements audit and its reporting timetable and other matters.
- Undertaking effectiveness review of the external audit service to inform recommendations to the Council of Governors as noted earlier in this section of the report.

The Chief Executive, as the Trust's Accounting Officer, is responsible for the preparation of the financial statements prior to them being audited by the external auditors. These responsibilities are detailed within the statement of Accounting Officer's responsibilities and in the Independent Auditor's report.

The Audit Committee gives full consideration to any significant risks and areas of audit focus raised in the external audit plan. In 2020/21 the three areas of audit focus related to management override of controls, risk of fraud in revenue recognition and valuation of property, plant and equipment.

In each of these areas, the Committee has been able to place reliance on work undertaken by the external auditors, Mazars LLP, as part of the work that they have undertaken to enable them to develop their audit opinion.

Compliance with NHS Foundation Trust Code of Governance

The Trust continues to seek to comply with the NHS Foundation Trust Code of Governance (the Code) which is issued to assist NHS foundation trust boards develop their governance arrangements in line with best practice.

The Code operates on a comply or explain basis and foundation trusts are required to report on how they apply the Code within their Annual Report. While there is a requirement to adhere to main principles of the Code, so long as reasons for any deviation from individual code provisions are explained and that alternative arrangements reflect the main principles of the Code, non-compliance is permitted.

Compliance with the Code

The Board of Directors considers the Trust compliant with main principles of the NHS Foundation Trust Code of Governance.

Details of how the Trust has applied the Code principles and complied with its provisions are set out in relevant sections of this Annual Report. In seeking to continually develop its governance arrangements, where action has been identified to further strengthen compliance against a Code provision this has also been described.

The disclosures required by the Code in relation to the roles and activities of the Board of Directors, its statutory committees and the Council of Governors and Membership are outlined earlier in this Accountability Section.

Required statements of disclosure relating to the functioning of the Board of Directors' Nomination and Remuneration Committee are contained within the Remuneration Report.

A review of compliance against individual code provisions has been undertaken. Explanations for areas of non-compliance are outlined here:

B.1.2 *At least half the Board, excluding the Chairman, should comprise Non-Executive Directors determined by the Board to be independent.*

The appointment of a substantive Medical Director (Operations) as an additional Executive member of the Board of Directors from December 2020 has resulted in the total number of Executive Directors increasing in-year from seven to eight. This change in the composition of the Board has impacted on the balance of independence on the Board of Directors, in that the number of Executive Directors (eight) became greater than the number of Non-Executive Directors (seven, excluding the Chair). Additionally, the appointment of Trust Chair from within the

Board's existing membership created a Non-Executive Director vacancy from 1 January 2021.

In line with its responsibility for giving consideration to the structure, size and composition of the Board, the Board of Directors' Nomination and Remuneration Committee (NRC) agreed to make a recommendation for the number of independent directors on the Board to be increased. Work has taken place to make appointments to both Non-Executive Director positions from early 2021/22. Through recent review of Non-Executive Director responsibilities and areas of focus, the Board of Directors has satisfied itself that, until these positions are filled, arrangements are in place to ensure meetings of the Board and its Committees support required quoracy and Non-Executive Director chair responsibilities.

B.6.2 *Evaluation of the boards of NHS foundation trusts should be externally facilitated at least every three years.*

While an independent review has not been commissioned to the Code's suggested timeline, the Board has undertaken facilitated self-assessment of its leadership and governance arrangements using the well-led framework and uses this as a key instrument to critically evaluate the Trust's quality governance arrangements.

Supported by its internal auditors, the most recent developmental review undertaken in 2018/19 identified some clear areas for development, focus on which was placed in preparation for the Trust's July 2018 Care Quality Commission (CQC) inspection and its well-led component. The Trust has progressed recommendations from each of these assessments, and from its own internal Board effectiveness review work, and is continually developing its leadership and governance arrangements.

Under transitional monitoring review arrangements introduced by the CQC during 2020/21 the Trust has participated in a review against the CQC well-led domain. The review took place virtually with no matters raised for immediate escalation.

The Audit Committee has agreed to keep the scheduling of independent evaluation of the Board under review as part of its annual objectives for 2021/22.

B.7.4 *Non-Executive Directors, including the chairman, should be appointed by the Council of Governors for specified terms subject to re-appointment thereafter at intervals of no more than three years and to the 2006 Act provisions relating to the removal of a director.*

The Standing Orders for the practice and procedure of the Board of Directors set out the term of office for the Chair and the Non-Executive Directors. These are reviewed regularly and it has been agreed to maintain the term of office at four years, rather than the three years as recommended in the Code.

The Board of Directors and the Council of Governors agree that this provides the Board with additional stability and continuity without compromising independence.

Arrangements are in place for a review of independence to be undertaken routinely as part of each second term re-appointment and a statement is made within the Annual Report by the Board of Directors with regard to each Non-Executive Director's independence.

Due regard was also given to determining independence in respect of the appointment of Annette Laban as Trust Chair on the basis of length of previous Non-Executive Director tenure. On recommending the appointment to the Council of Governors, its Nomination and Remuneration Committee confirmed that it was satisfied through testing at interview and triangulation with feedback sought from members of the Board of Directors that Annette was independent in character and judgement. As previously agreed by Governors at a Governors' Forum meeting held on 27 February 2020 and noted at the Council of Governors' Nomination and Remuneration Committee held on 18 May 2020 Annette's appointment will be for one term of office.

The next review to seek assurance on arrangements to ensure Non-Executive Director independence has been scheduled within the 2021/22 workplan of Audit Committee.

D.2.3 *The Council of Governors should consult external professional advisers to market-test the remuneration levels of the chairperson and other non-executives at least once every three years and when they intend to make a large change to the remuneration of a Non-Executive.*

The Council of Governors has not appointed external professional advisors to market-test the remuneration levels of the Chair and other Non-Executive Directors but the Trust participates in NHS Providers remuneration surveys and other industry benchmarking exercises. This benchmarking data is used by the Council of Governors Nomination and Remuneration Committee when making recommendations to the Council of Governors in relation to the remuneration of the Chair and the Non-Executive Directors.

Regulatory ratings

NHS Oversight Framework

NHS England and NHS Improvement's NHS Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- quality of care
- finance and use of resources
- operational performance
- strategic change
- leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where 4 reflects providers receiving the most support, and 1 reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach, or suspected breach, of its licence.

Segmentation

NHS Improvement has reviewed the Trust's performance and information available to it and placed the Trust in Segment 2. This segmentation information is the Trust's position as at March 2021. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Accountability Report signed by the Chief Executive
in capacity as Accounting Officer

Kirsten Major
Chief Executive
11 June 2021

Statement of Accounting Officer's Responsibilities

Statement of the Chief Executive's responsibilities as the Accounting Officer of Sheffield Teaching Hospitals NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Sheffield Teaching Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Sheffield Teaching Hospitals NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the Annual Report and Accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy, and
- prepare the financial statements on a Going Concern basis and disclose any material uncertainties over going concern.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the Foundation Trust's auditors are unaware, and I have taken all steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Kirsten Major
Chief Executive
11 June 2021

Annual Governance Statement 2020/21

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Sheffield Teaching Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Sheffield Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2021 and up to the date of approval of the Annual Report and accounts.

Capacity to handle risk

The Board of Directors is responsible for reviewing the effectiveness of the system of internal control and for ensuring that the Trust has effective systems and structures in place for managing all types of risk that threaten the Trust's ability to meet its aims and objectives, and the achievement of its values.

Work has taken place during 2020/21 to embed the Trust's revised framework for risk management introduced in-year. To support an integrated approach to risk management the framework defines the structures and processes in place to identify, manage and eliminate or reduce risks to a tolerable level. It clarifies accountability arrangements for the management of risk within the Trust from Board to Ward, setting out the responsibility of Executive Directors and Senior Managers in respect of leadership in risk management and confirms the role that all staff within

the organisation have in relation to responsibility for the identification and reporting of risks and incidents.

Operational responsibility for risk management sits within clinical and corporate directorates. Each directorate is required to have processes in place by which risks are identified, assessed and managed at a local level, and escalated as required in accordance with the Trust's policy framework. The Trust's Healthcare Governance Arrangements Policy and Framework for Delivery document describes the local healthcare governance structures, systems and processes that clinical directorates and corporate departments need to have in place to manage risk.

The committee structure of the Board of Directors provides assurance on, and challenge to, the Trust's risk management process. Each chaired by a Non-Executive Director to enhance independent scrutiny, these committees are the key structures in ensuring quality, safety and management of risk, and provide the mechanism for managing and monitoring risk throughout the Trust and for assurance reporting to the Trust Board of Directors. Executive Directors provide leadership on the management of key areas of risk commensurate with their roles and are represented across the Board committee structure.

The Trust Executive Group (TEG) is responsible for the implementation of risk management and related assurance mechanisms. Individual Executive Directors are responsible for overseeing a programme of risk management activities in their areas of responsibility and the Trust Executive brings together the corporate, workforce, clinical, information, research, reputational and governance risk agendas.

With delegated authority from the Board of Directors, the Audit Committee has overall responsibility for integrated governance, risk management and internal control. It oversees the system of internal control and governance and overall assurance process associated with managing risk to ensure that risks to the delivery of the Trust's services are identified and addressed. Strategic risks are reported to the Board of Directors and Audit Committee via the Integrated Risk and Assurance Report (IRAR).

Staff training and guidance on the management of risk

Mandatory risk management and health and safety awareness training are incorporated within the Trust's induction programme for all new starters. The frequency and level of risk management training is identified through training need assessments, ensuring that individual members of staff have the relevant training to equip them for their duties and level of responsibility.

Additionally, a range of policies is in place and available to staff via the Trust's intranet which describe the roles and responsibilities in relation to the identification, management and control of risk. Staff are made aware of these policies and are actively encouraged to access them to ensure that they understand their own roles

and responsibilities. The Patient and Healthcare Governance Department provides additional support, guidance and expert advice to staff on risk management. The department assists risk owners in identifying, assessing and managing and reviewing risks. Specifically, it supports all areas of the Trust in the use of the Datix Risk Management System as the electronic Trust-wide Risk Register.

In 2020 the Trust commissioned external training for senior managers to support them in fulfilling their roles and responsibilities relating to the management of risk. This training reflected the revised structure of the newly implemented Framework for Risk Management described below.

The Trust takes all opportunities to learn from good practice and has a breadth of mechanisms in place to support this. These range from clinical supervision, reflective practice, peer review work and clinical audit. Learning from root cause analysis investigations and information such as trends in incidents, complaints and claims is used to continually enhance and improve standards of patient care by feeding into our quality improvement programme. During 2020 the Trust reviewed and revised its incident management policy and also issued new Trust-wide action plan guidelines to support robust action planning following incident investigations. Major reports from healthcare regulators are also routinely used to identify learning from significant incidents and events in other healthcare organisations.

The risk and control framework

Framework for risk management

As referred to above, the Trust's Framework for Risk Management describes the Trust's overall risk management process, within which the operation of an Integrated Risk and Assurance Report (IRAR), and Trust-wide Risk Register ensure that risk management is an integral part of clinical, managerial and financial processes across the Trust.

The framework defines the role of all staff in managing risks with associated procedural documents clearly outlining a systematic approach to the identification, evaluation and control of risk, which commences with a structured risk assessment process.

Local risks are reported and entered onto the Trust's Risk Register via directorate governance groups and Trust management committees. The use of a standard assessment tool to identify risks ensures a consistent approach is taken to the evaluation and monitoring risk across the Trust. Additionally, the use of a grading matrix of likelihood and consequence to produce a risk score enables risks to be prioritised against other risks on the Risk Register. Local risks with a score of three or below are managed in the area in which they are identified; with all risks graded as above three are entered onto the Trust's Risk Register.

A target risk score is assigned to each risk to ensure that risks are controlled within a timely manner and to an acceptable level. The Board of Directors has developed a Risk Appetite Statement that clearly articulates what risks it is willing or unwilling to accept in order to achieve the Trust's strategic aims. This acknowledges that risk is inherent in the provision of healthcare. As a general principle the Trust has a low tolerance for all risks that have the potential to expose patients, staff, visitors and other stakeholders to harm, that compromise the Trust's ability to deliver operational services, that adversely impact the reputation of the Trust, have severe financial consequences or result in non-compliance with law and regulation. The statement then defines tolerances for balancing different elements of risk, including patient safety, reputation, workforce and financial / value for money, based on how much, or little the Trust wishes to commit in terms of risk.

Risk control measures are identified and implemented through action plans to achieve the target level of risk. Oversight of these action plans takes place in line with the newly articulated structure for the cascade and escalation of risk and assurance. These arrangements involve the consideration of all locally approved new and existing risks scored as eight and above by the Trust's Risk Validation Group (RVG). This group reviews each risk to validate the risk score; to scrutinise and challenge the adequacy of the risk description, the controls and the mitigating action plan.

As part of implementation of the refreshed risk escalation structure, reporting and oversight arrangements have been strengthened through a newly formed Safety and Risk Committee with responsibility for ensuring robust and effective arrangements are in place for the management and monitoring of matters relating to safety and risk across the Trust. RVG reports to this committee and through senior-level representation from both corporate and clinical directorates, the committee considers risk aggregation and onward reporting to TEG of aggregated operational risks and those with a risk score of 15 or more as part of the standing operating procedure for the management of the Integrated Risk and Assurance Report (IRAR).

A redefined Safety and Risk Forum provides a networking, learning and information sharing forum for directorate risk and governance leads. Other specialist groups with specific risk management responsibilities, for example, the Infection Prevention and Control Committee, Radiation Safety Steering Group and Information Governance Committee also support effective risk management.

The IRAR forms the mechanism for proactively assessing risk and control at the very highest level and seeks to provide assurance that there is effective management of key risks to the delivery of the Trust's strategic aims. Structured around a set of Principal Risks identified and evaluated by TEG, it reports the controls in place to mitigate and manage each risk, and the assurances available to indicate that the controls are effective. Detailed scrutiny of controls and assurances is performed by a relevant Board Committee. The Healthcare Governance Committee, Finance and

Performance Committee, Human Resources and Organisational Development Committee each has oversight responsibility for sections of the IRAR that align with the remit of their own terms of reference. Via their Non-Executive Chair, each reports formally to the Board of Directors, to confirm delivery of assurance or escalate matters as necessary. Focus has been maintained during 2020/21 on embedding a programme of IRAR Deep Dive reviews through the Board committee structure and on using conclusions drawn from these to further inform and drive the Board's assurance framework.

During 2020/21, operation of the Trust's risk and control framework responded to the need to support the organisation being run through a full Major Incident Command and Control Structure for periods of time. On initial establishment of a command structure during March 2020 and into 2020/21, the development and adoption of dynamic risk architecture supported the Trust to manage the operational pressures experienced during the first wave of the Covid-19 pandemic.

The deployment of a prompt response to a significant change in circumstances extended to include a review of arrangements for Board assurance and governance. This was undertaken with acknowledgement that a strong system of governance, even in times of crisis, is essential to ensure decision making continues to be undertaken within agreed frameworks. Approved by the Board of Directors in April 2020, these arrangements balanced the need to ensure that resources were focused on necessary clinical and operational matters to enable safe and sustainable service delivery, while maintaining the robustness of decision making in a fast moving environment and providing the appropriate level of Board assurance. While temporary changes were made to the Trust's governance arrangements, the Board of Directors and all Board committees continued to meet during this period under agreed principles for streamlining meetings.

Risk management under command structure arrangements has involved implementation of a risk log process with a chain of risk escalation from Bronze Command (operational) to Silver Command (tactical) to Gold Command (strategic). While managed through this highly dynamic emergency planning structure, the Covid-19 risk architecture has operated in parallel to the Trust's business as usual risk management and assurance arrangements.

Re-established, in part or whole, during successive waves of the pandemic, the command structure, supported by dynamic risk management and streamlined governance arrangements, has provided a robust and transparent method of mitigating, preparing and responding to the demands of the Covid-19 pandemic. While in place, it has formed the structure within which risks relating to the Trust's ability to respond effectively to Covid-19 and its impact on the delivery of the Trust's services are being managed.

Due to their strategic impact, management of Covid-19 related risks has involved assurance and oversight functions performed by TEG and the Board of Directors.

During the first quarter of 2020/21, the IRAR framework was adapted to support the Board of Directors and Board committees to focus on strategic risks identified under Covid-19 command and control arrangements and their alignment to IRAR Principal Risks.

From quarter two, these risks have been factored into controls and mitigating actions described within the IRAR's underpinning framework and the IRAR has therefore continued to provide the mechanism for the Board of Directors to assess the ongoing impact of Covid-19 on key strategic risks.

Over the course of the year increased recognition has been given to the fact that the Trust's strategic landscape will be dominated by the impact of Covid-19 for some time. As such, the recalibration of IRAR Principal Risks for 2021/22 will be highly influenced by the impact of Covid-19 and, hence, the controls and assurances that have been driven by the Trust's command structure arrangements will need to be carried forward as business as usual.

The Covid-19 pandemic is a clear example of a significant event that impacts on the Board's appetite and tolerance of risk. In agreeing arrangements for the management of Covid-19 related risks within the emergency command structure, a formal review of the Risk Appetite Statement was undertaken outside its annual cycle in April 2020. While acknowledging that the pandemic would result in a heightened risk portfolio across the Trust, after careful consideration it was agreed that there was no need to amend the current risk appetite statement. Repeated reviews were undertaken during the early part of 2020/21 to seek reassurance around the validity of this approach. This then informed a return to the routine annual review schedule for the Risk Appetite Statement.

Quality governance arrangements

The Trust's quality governance and leadership structure ensures that the quality and safety of care is being routinely monitored across all services. The robust quality performance, risk management processes and reporting mechanisms in place to review and challenge performance and variation can be outlined as follows:

- Board oversight of quality issues through the Healthcare Governance Committee; a formal committee of the Board providing assurance that adequate quality governance structure, processes and controls are in place across the Trust for the continuous monitoring and improvement of safe and effective patient care.
- A clear and embedded framework described within a Healthcare Governance Arrangements Policy and Framework for Delivery which supports consistency of structures, systems and processes for local governance and risk management arrangements across clinical and corporate directorates.

- Strategic principles approved by the Board within which the structure and process for selecting and overseeing the implementation of annual quality priorities with involvement from patients, staff, Governors and other key stakeholders is implemented. Our current Quality Strategy will be refreshed during 2021/22 to reframe our aspirations and approach to quality improvement within the context of a new corporate strategy for the Trust.
- Well embedded reporting arrangements to the committee structure of the Board via a supporting framework of Executive-led sub committees and management groups. This involves monthly consideration of an Integrated Performance Report (IPR) presenting RAG rated performance and exception narrative for national and local performance standards at a Trust and directorate level. Reporting arrangements also include quarterly consideration of an Integrated Quality and Safety Report bringing together incidents, claims, inquests, patient feedback, complaints, risk and clinical audit data.
- A deep dive analysis of performance on an agreed specific topic of interest presented to the Board of Directors meeting held in public.
- Open and honest culture of reporting of incidents, risks and hazards promoted by the Board of Directors and supported by structured processes including online reporting systems for incident reporting and the investigation of Serious Incidents.
- There are also clear and transparent processes for sharing lessons learned following investigation with reports shared at directorate and Trust-wide level through relevant committees and groups. Learning from complaints, clinical audits, external visits, inspections and accreditations and from patient feedback is also cascaded from Ward to Board, across clinical and non-clinical areas through the Safety and Risk Forum, the Safety and Risk Committee and the Healthcare Governance Committee.

Assurance on Care Quality Commission (CQC) compliance

The Trust's risk and performance management arrangements inherently support the monitoring of ongoing compliance with the requirements for registration set by the CQC. Any risk to compliance identified through routine performance monitoring is escalated through the Trust's risk management framework and entered, as appropriate, onto the IRAR as a risk to the delivery of a Trust strategic aim.

A range of mechanisms is in place to monitor compliance with the CQC's five domains of safe, effective, caring, responsive and well-led. Through the Healthcare Governance Committee the Board of Directors reviews a range of metrics on patient experience, clinical effectiveness and patient safety reported within the quarterly Integrated Quality and Safety Report. This Committee also receives a monthly report on CQC compliance and reports the publication of findings from external CQC reviews and CQC national surveys.

The Trust was inspected by the CQC in June 2018 and maintained an overall rating of Good with many services rated as Outstanding.

On 18 March 2021 the Trust received a letter from the CQC requesting information regarding mental health governance processes, triggered by a specific Serious Incident. The Trust responded to the request to provide additional assurance and an action plan. The CQC replied on 26 March 2021 and was satisfied that this provided sufficient assurance pertaining to the risks identified and that immediate enforcement action was not required. However, the Trust was required to take action and provide further assurance with regard to training, risk assessments and the environment. The Trust is required to update the CQC on a regular basis on delivery of the agreed action plan.

Following an unannounced inspection by the CQC of the maternity service in March 2021 the Trust was informed that due to initial findings on some processes and systems the CQC were imposing temporary conditions on our licence and required an action plan to be submitted by 12 April 2021. Immediate actions have been taken by Maternity Services to address and, where possible immediately rectify, as many of the issues as possible and to develop plans for the remainder to be addressed as a priority. The Trust submitted an action plan to the CQC on 9 April 2021. Monitoring of which will be undertaken through a Maternity Oversight Committee reporting into the Trust Executive Group and providing assurance to the Board through the Healthcare Governance Committee.

The Trust has ongoing engagement with the CQC through monthly update and quarterly engagement meetings. Formal engagement meetings are attended by the Medical Director (Operations), Assistant Chief Executive and the Head of Patient and Healthcare Governance. The monthly meetings held during 2020/21 have focused on operational updates in relation to Covid-19 and attended by the Head of Patient and Healthcare Governance and the Compliance Manager.

In addition, CQC reviews have been undertaken in relation to CQC's Patient FIRST framework for emergency medicine and the Trust's vaccination programme. All reviews have taken place virtually with no matters raised for immediate escalation.

Well-led framework

The Board of Directors undertakes self-assessments against the well-led framework (NHSI, June 2017) and uses this as a key instrument to critically evaluate the Trust's quality governance arrangements. The Trust's most recent review, undertaken in 2018/19, involved facilitated self-assessment supported by our internal auditors. Board member survey work and one-to-one interviews with lead Executive Directors complemented a desktop review of evidence and generated for discussion with the Board of Directors a baseline assessment of Trust compliance for each key line of enquiry.

This review identified some clear areas for development. Focus was placed on these areas as part of preparation for the Trust's June 2018 Care Quality Commission (CQC) inspection and, in particular, the well-led assessment component. The Trust has progressed recommendations from each of these assessments, and from its own internal Board effectiveness review work, and is continually developing its leadership and governance arrangements.

Under transitional monitoring review arrangements introduced by the CQC during 2020/21 the Trust has participated in a review against the CQC well-led domain. This review took place virtually with no matters raised for immediate escalation.

Managing risks to data security

The reporting and management of both data and security risks are supported by ensuring that all employees of the Trust are reminded of their data security responsibilities through education and awareness. Information governance training forms part of mandatory training requirements. Regular reminders and lessons learned from local incident reviews and risk assessments are shared through staff communications.

In addition to mandatory staff training, a range of measures is used to manage and mitigate information risks, including physical security, data encryption, access controls, audit trail monitoring, departmental checklists and spot checks. In addition, a comprehensive assessment of information security is taken annually as part of the Data Security and Protection Toolkit and further assurance is provided from internal audit and other reviews.

The effectiveness of these measures is reported to the Information Governance Committee. This includes details of any personal data-related Serious Incidents, the Trust's annual Data Security and Protection Toolkit score and reports of other information governance incidents and audit reviews.

Information governance

There were no serious incidents during this period. There was however a complaint to the Information Commissioner's Office (ICO). This concerned the retention of a leaver's staff record over the eight year legal framework. Following a Subject Access Request for copies of their staff record under Data Protection legislation, the leaver was supplied with information in excess of the eight year retention period.

If there is no legal and professional privilege involved in retention such information should have been destroyed. If there is a reason to retain (such as the legal requirements of the Infected Blood Inquiry and the Inquiry into Child Sexual Abuse) the personal information should not be released. Following an investigation by the Human Resources and Information Governance departments, a new standard

operation procedure (SOP) was developed whereby all leavers files would be centralised and their retention periods managed by the Human Resources Department. The SOP was approved by the Trust Executive Group and its generation satisfied the ICO from a legal stand point. As a consequence, the complaint was closed.

There are robust and effective systems, procedures and practices in place to identify, manage and control information risks. Whilst the Board of Directors is ultimately responsible for information governance, it has delegated authority to the Information Governance Committee which provides assurance to the Healthcare Governance Committee and is chaired by the Medical Director (Development), who is also the Trust Caldicott Guardian. The Board appointed Senior Information Risk Owner (SIRO), is the Informatics Director. The Trust Information Governance, Caldicott and SIRO Support Manager, and his team support both the above roles and, as such is also a registered Caldicott Guardian and the Trust Data Protection Officer (DPO).

The Information Governance Committee Terms of Reference brings together all the statutory requirements, standards and best practice in conjunction with the Trust's Information Governance Policy and is used to drive continuous improvement in information governance across the organisation. The development of this policy framework is informed by the results from the Data Security and Protection Toolkit (DSPT) annual assessment and by participation in the Information Governance Committee, the IT Security Group and the Cyber Security Team.

Supported by relevant policies and procedures, notably the Procedures for the Transfer of Person Confidential Data (PCD) and Other Sensitive and Confidential Information, and the Confidentiality - Staff Code of Conduct, the Trust has an ongoing programme of work to ensure that PCD is safe and secure when it is transferred within and outside the organisation. The Internet - Acceptable Use Policy, the Data Protection Policy and the Confidentiality - Staff Code of Conduct have been reviewed and updated to ensure robust information governance in response to the changing use of messaging applications and social networking sites.

All Trust laptops and USB data sticks issued to and used by staff are encrypted. The introduction of port control and an approved list of removable storage media are planned to be introduced as part of the actions to protect the Trust IT systems from malware and cyber-attack.

In accordance with the UK Data Protection legislation, the Trust Data Protection Officer (DPO) overviews the use of Data Protection Impact Assessments, the Data Protection Notification and Mapping Form, together with the Information Asset Policy. A centralised major information asset register is in place which supports the DPO role. All Trust Information Asset Owners report to the SIRO in respect of areas of risk. Any concerns identified through the registration and management of the

Information Assets will be pursued through accepted line management arrangements. Failure to deal with a concern through that route will be addressed by the DPO and the SIRO with the appropriate Information Asset Owner within the Trust.

There were no Serious Incidents relating to information governance classified as level two (2) during 2020/21.

Principal in-year risks

The impact of the Covid-19 pandemic has had a significant bearing on the Trust's strategic risk profile. As described above, the Integrated Risk and Assurance Report (IRAR) framework was adapted in-year to ensure that it provided the mechanism to effectively support the Board of Directors and its Committees to assess the ongoing impact of Covid-19 on key strategic risks.

In-year risks logged under incident control arrangements aligned to the Trust's key Principal Risks are listed below and also described within the Performance Section of this Annual Report on pages 19 and 20.

- *Operational pressures and risks to the provision of quality of care*

In each successive wave of the Covid-19 pandemic the Trust has identified and managed a number of potential risks associated with the ability to maintain high quality clinical outcomes during periods of challenging operational pressures. The most significant of these risks have included:

  - An increase in infectious patients experiencing acute respiratory symptoms requiring admission, coupled with staffing pressures leading to demand for general inpatient beds exceeding capacity;
  - An increase in Covid-19 patients requiring ventilation or intensive care leading to demand for Critical Care exceeding capacity; and
  - High volumes of requests for Covid-19 testing for patients and staff resulting in potential delays in processing tests, impacting on the effective management of Covid-19 positive patients and delaying the return to work of staff who test negative.

In response to the Covid-19 pandemic the Trust established a full Major Incident Command and Control Structure which entailed the organisation being run through Bronze, Silver and Gold Command. This provided a robust and transparent method of mitigating, preparing and responding to the demands of the pandemic. Through these emergency planning arrangements tactical oversight of the Trust's operational position and response to escalations of operational risks has been undertaken at Silver Command level.

Supported by a Clinical Expert Group the function of Silver Command has been to co-ordinate the mitigations put in place to minimise the impact on the Trust of significant operational pressures across its own services, and those regionally and nationally. This has included developing actions to reconfigure existing capacity, reviewing significant single service changes, implementing rapid innovation, overseeing strategic communications and acting as the point of liaison with external organisations.

- *Staffing / skill mix not adequate to provide high quality services*

There are long standing challenges across the NHS in recruiting sufficient numbers of appropriately qualified clinical staff in some professions and roles. One example being in nursing, where the Trust mitigates nurse vacancy levels through proactive reviews of staffing to ensure that each ward area is staffed according to real time need and with reference to best practice staffing models.

At the height of successive waves of the pandemic not having appropriately skilled or trained staff was identified as a risk in preventing the Trust from implementing an effective Covid-19 escalation plan. This was due to national shortages across key areas of the workforce being compounded with Covid-19 related absences.

Key to mitigating this risk was a central workforce support team that was established at Silver Command level to respond to workforce capacity requests from across the Trust. A key function of this team was the central co-ordination of the deployment of medical, clinical and non-clinical staff. In addition, this team undertook detailed analytical processes to understand the availability and utilisation of staff and home working.

- *Staff health and wellbeing and resilience is negatively impacted*

During the last 12 months the Trust has recognised and placed significant focus on the risks associated with the Covid-19 pandemic and its impact on staff health, wellbeing and resilience.

The ongoing nature of the pandemic, uncertainty around next phases and the demands on staff in terms of providing care to patients, leadership demands and anxiety and pressures within and outside the workplace all have the potential to negatively impact on the health, wellbeing and resilience of our workforce, leading to increased staff sickness levels and poor staff engagement.

Acknowledging the need to safeguard staff health and wellbeing, the Trust introduced risk assessments (QRISK3) to identify and support those colleagues with underlying health conditions who may be more at risk from complications of Covid-19. Additionally, staff were all offered an individual Covid-19 impact assessment. At

the start of the pandemic we also acted promptly to introduce Covid-19 testing for all staff and their families.

Our well-established Employee Assistance Programme has continued to be available 24 hours a day, seven days a week. Over the course of the pandemic we have extended the range of wellbeing resources available to staff as described in the Staff Report section. Colleagues have also been able to access peer support via leadership circles run within the Trust by the Organisational Development Department.

- *Risk of disruption in essential service delivery and non-compliance with national guidance due to a lack of availability of key supplies*

From the start of the pandemic, there has been a heightened risk around the availability of key supplies due to national / international shortages of equipment, the most notable of which being personal protective equipment (PPE).

The inability to source necessary supplies or delays in the receipt and distribution of stock, particularly during wave one of the pandemic, was acknowledged as a key risk to essential service delivery, safe working practices and potential non-compliance with national guidance.

The need to support the agile placement of orders for the purchase of PPE was recognised within the Command Structure and the Trust Board of Directors agreed that Gold Command could approve the placement of such orders for patient and staff protection, with any orders over standard delegated limits being retrospectively reported through the Audit Committee.

This, together with establishing arrangements for the off-site storage of PPE, allowed the Trust to bulk-purchase essential PPE items for hospitals across the region and ensured the NHS in Sheffield and South Yorkshire did not run out of essential supplies.

- *Increased rates of nosocomial infection lead to patient and staff harm*

The highly infectious nature of Covid-19, high volumes of infectious patients and the fixed nature of the hospital environment has placed significant strain on efforts to minimise the risk of hospital based transmission and prevent increased rates of nosocomial infection resulting in increased incidence of infectious diseases across our staff and the public.

The Trust has implemented a range of robust systems to respond appropriately to the challenges presented by Covid-19. The Infection Prevention and Control Team has rapidly implemented both tried and tested and innovative methods of infection prevention and control and outbreak management to mitigate the risk of nosocomial infection, including the screening patients on admission to hospital and mandating

self-isolation in patients prior to elective admissions. Patients who are symptomatic with potential Covid-19 are managed via a symptomatic or confirmed route of admission through the relevant assessment beds and asymptomatic patients are placed via a different pathway.

The infection control nurses are instrumental in supporting the Patient Flow Team and ward based teams in managing the appropriate and safe placement of patients and we have established a Covid-19 Outbreak Control Team (OCT) to review outbreaks and provide advice and guidance to support patient management and safe patient placement in the event of outbreaks.

Assurance has been provided within an Infection Control Board Assurance Report (BAF) and Infection Prevention and Control updates submitted to the Board of Directors.

Other key risks during 2020/21

EU Exit

The Trust maintained its emergency planning arrangement in response to the UK leaving the European Union and actively monitored associated risks relating to potential significant disruption to the supply of goods and services, in particular medicines and devices as well as potential staff shortages.

Covid-19 specific fraud risks

During 2020/21, it was recognised that emergency measures taken during the Covid-19 pandemic may expose the Trust to an increase risk of fraud. The Trust was supported by its Local Counter Fraud Specialist who shared information gathered on new and emerging threats facing health bodies, for example procurement fraud, cyber fraud and security risks. This information was shared in the form of regular briefings and quarterly newsletters disseminated though staff communication bulletins to promote action to be taken to strengthen controls. Targeted guides on specific Covid-19 fraud risks were also issued to the Trust's procurement, finance and human resources departments.

Increased focus was placed by the Audit Committee on oversight of the controls in place and assurances provided to the Board of Directors on a number of key areas of potential fraud risks. These included the heightened fraud risk in relation to procurement of personal and protective equipment (PPE) and also arrangements in place for accepting and recording gifts and donations offered in response to Covid-19.

Major risks 2021/22

Over the course of 2020/21 it has become evident that the Trust's strategic landscape will continue to be dominated by the impact of Covid-19 for some time. As such there will be a need to continue to mitigate all the in-year risks described above.

To reflect the continuing impact of Covid-19, IRAR Principal Risks have been refreshed for 2021/22 and risk articulation statements and scores have been recalibrated to incorporate the maturity of risk articulation under incident management arrangements.

Major risks, not featured above which will have an impact into 2021/22 include:

- *Risks that delayed treatment may adversely impact health outcomes*

Covid-19 has resulted in significant numbers of patients having their treatment delayed or cancelled due to a focus on Covid-19 pathways. In order to mitigate the impact on the health outcomes of our patients and public health in the longer term the Trust has implemented a caseload management approach whereby all patients, where a pathway has been delayed are reviewed on a regular basis.

Undertaken at Directorate level, this approach provides visibility of patients who are either waiting to be seen for a first appointment, for a test, for treatment or waiting for review and that through regular review ensures there is clinical intervention at the appropriate time.

A Performance Caseload Overview Group (PCOG) provides oversight and assurance that all risks associated with pathways are being logged and managed appropriately at directorate level.

- *Disparity between capacity and demand impacts waiting times and patient experience*

There are risks associated with increased demand and the need to recover waiting list backlog while managing planned care alongside fluctuating Covid-19 demand. This is likely to result in disparity between capacity and demand, impacting on waiting times and patient experience and leading to underperformance against national quality and performance standards.

These risks will require focused operational review and managing the longer term impact of Covid-19 will require significant changes to the way we work. The last year has demonstrated that the provision of care and our interactions with our patients will be profoundly different from how it was before the pandemic and we will need to embrace new ways of working and manage these changes through well embedded governance and leadership arrangements and effective partnership working.

- *Inequalities and variation in care provision impact on provision of responsive, high quality care*

There is recognition nationally that health inequalities within society are widening as a result of the Covid-19 pandemic. The Trust has identified a lack of cultural competency across its service delivery and the disproportionate impact of ill health on people who already experience disadvantage and exclusion which will lead to inequalities and variation in care provision. As one of its most significant strategic risks this impacts on the ability to provide responsive, high quality patient care that meets the needs of the population we serve.

The Trust's equality, diversity and inclusion workstream is key to supporting effective mitigation of this risk, more details of which are set out on page 50 of the Annual Report.

- *Failure to sustain financial stability due to an inability to predict future income*

Our external strategic landscape continues to be driven by policy focused on managing systems rather than organisations, recognising the need to integrate services. This is driving uncertainty around future funding models and a change to future commissioning arrangements, including allocation of resources at an Integrated Care System (ICS) level.

The inability to predict future income and the impact of this on the Trust's business planning and resource allocation processes will require the need to effectively mitigate associated risks threatening the financial stability of the Trust.

We will need to continue to keep abreast of developments relating to funding arrangements, maintain active engagement in regional system work and mitigate any risks emerging from revised arrangements.

- *Inability to appropriately identify and utilise capital monies in future years*

A future strategic financial risk relates to changes in the allocation of capital funding to a system-wide Operational Capital Envelope and a failure to secure sufficient capital funding to fund necessary investment.

Again, there will be a need to continue to closely monitor developments in capital allocations to ensure the Trust is best placed to identify future capital monies and progress plans.

Compliance and validity of the NHS Foundation Trust condition 4 (FT Governance): Corporate Governance Statement

The Board of Directors annually considers the Corporate Governance Statement with a view to confirming compliance with condition FT(4) of the provider licence. To assure validity of this statement, a schedule of evidence of compliance with each element of the declaration is prepared by the Trust Executive Group (TEG) for review by the Board of Directors prior to final approval.

All statements were confirmed in the May 2021 review with no unmitigated risks to compliance identified. The Trust believes that effective systems and processes are in place to maintain and monitor the following:

- The effectiveness of governance structures
- The responsibilities of Directors and Board committees
- Reporting lines and accountabilities between the Board of Directors, its committees and TEG
- The submission of timely and accurate information to assess risks to compliance with the Trust's licence
- The degree and rigour of oversight the Board of Directors has over the Trust's performance.

Engagement with public stakeholders in risk management

The Trust engages public stakeholders in identifying and managing risks which may impact on them in a number of ways:

- As a foundation trust the organisation aims to make best use of its Membership and of its Council of Governors. Through relevant working groups, Governors are kept apprised of proposed changes, including how potential risks to patients will be minimised. We also take opportunities to engage the Council of Governors on key issues and risks by consulting them on the development of our annual Operational Plan.
- Through selection and discussion of quality objectives at a bi-annual meeting of the Quality Board, reporting into the Healthcare Governance Committee, which incorporates stakeholder membership including staff, Governors, Healthwatch Sheffield and voluntary and community sector representation.
- The Trust employs a wide range of methods to capture feedback from patients, their families and carers including national and local surveys, social media, complaints, and the Friends and Family Test, acknowledging the value of this feedback as an early warning mechanism within its risk management processes.

Assurance that staffing processes are safe, sustainable and effective

Our staffing governance processes are safe, sustainable and effective and have been developed in line with National Quality Board guidance and recommendations within *Developing Workforce Safeguards*, (NHSI 2018). This is to ensure that the Trust deploys sufficient suitably qualified, competent, skilled and experienced staff, that there is a systematic approach to determine staffing levels and that this reflects current legislation and guidance.

Optimal staffing on our wards and departments is critical to providing safe, high quality care to our patients. We keep staffing levels and skill mix under constant review to ensure that each ward area is staffed according to real-time need and with reference to best practice staffing models. The Trust's Nursing and Midwifery Staffing Escalation Policy clearly defines the dynamic systems and processes that function daily to ensure that any shortfalls in staffing are mitigated. These are further supported by daily nurse staffing meetings to consider plans for staffing over the next 24 hours and an on-site senior nurse 24 hours a day.

During 2020/21, except for the period between March and April 2020 when national reporting was suspended, the actual and planned staffing levels on all our wards on a shift by shift basis were calculated and published on the Trust website. In line with national guidance, an exception report was presented through the Human Resources and Organisational Development Committee to the Board of Directors setting out those wards where staffing capacity and capability fall short of the plan, the reasons for the gap and the impact and actions being taken. For the period when national reporting was suspended, the Chief Nurse updated the Human Resources and Organisational Development Committee at its monthly meetings with regard to how the Trust was assured that it was continuing to provide appropriate levels of nurse staffing across the organisation.

Continuous monitoring of patient outcomes and quality indicators inform establishing nurse staffing levels and we use a range of tools to do this including a nursing and midwifery quality dashboard and ward monitoring systems. Twice a year each inpatient clinical area assesses the care needs of patients in their ward / department, using an evidence-based tool to help determine the nurse / midwifery staffing required to provide safe, compassionate and effective care. In nursing the tool is the Safer Nursing Care Tool (SNCT) and in midwifery it is Birthrate+. Informed further by professional judgement and evaluation of outcome measures, this establishment review is reported twice a year through the Human Resources and Organisational Development Committee to the Board of Directors, with the most recent report presented in March 2020. Due to the Covid-19 pandemic, the reviews for June 2020 and January 2021 were not able to take place, however the findings of the January 2020 review was presented to the March meeting of the Human Resources and Organisational Development Committee. In addition the Maternity Service underwent a review of its staffing using Birthrate+ during 2020.

As part of the Trust's annual business planning cycle, the planning of our workforce identifies staffing pressures, proposed service changes and other factors affecting our workforce provision. In July 2018, the Trust launched its People Strategy; a key element of which is our Workforce Redesign, Innovation and Planning (WRIP) workstream. Any planned workforce redesign or introduction of new roles is the subject of a full quality impact assessment review. Examples of where impact assessment reviews have taken place have included the development of nursing associates and physician associate roles.

Recognising the value of all clinical staff, the Trust regularly undertakes capacity and demand reviews to ensure the sufficiency of staff and has methods of escalation in place should any concerns regarding staffing levels be raised. All identified risks are assessed and logged onto the Trust Risk Register with mitigations put in place and closely monitored.

Recruiting sufficient numbers of appropriately qualified clinical staff, particularly nursing staff to be able to safely care for our patients, has been identified as a potential strategic risk to the delivery of the Trust's strategic aims. As such our Integrated Risk and Assurance Report (IRAR) provides a mechanism operational staffing risks to be escalated to the Board of Directors. During 2020/21, the Trust has seen a significant number of international registered nurses recruited and deployed and cohorts of nursing associates and midwifery support workers qualify and deployed to mitigate this risk.

Compliance statements

Care Quality Commission (CQC) compliance

As a provider of care, the Trust is registered and regulated by the Care Quality Commission (CQC). The Trust has an overall rating of Good, with many Outstanding features.

Following an unannounced inspection of the maternity service on 8 and 9 March 2021, the CQC imposed conditions on the Trust's registration. These included:

- The provider must implement an effective system to manage and respond to patient risk.
- The provider must implement an effective risk and governance system.
- The registered provider must implement an effective system to ensure that medical and midwifery staff have the qualifications, competence, skills and experience to care for and meet the needs of women and babies safely.

The final inspection report issued on 9 June 2021 lowered our rating for the Jessop Wing from Outstanding to Inadequate.

A comprehensive response was provided by the Trust within the timescales set. The CQC has indicated that it is fully satisfied with the Trust's response to date. Monitoring the delivery of the CQC action plan will be undertaken through a Maternity Oversight Committee reporting into the Trust Executive Group and providing assurance to the Board of Directors through the Healthcare Governance Committee.

Register of Interests

The Trust has published on its website an up-to-date Register of Interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past 12 months, as required by the *Managing Conflicts of Interest in the NHS* guidance[3] (NHSE, 2018).

This can be accessed from this link.

Arrangements were put in place during 2020/21 to ensure that gifts and donations offered to the Trust in response to Covid-19 were appropriately managed and logged for inclusion on the Register of Interests.

Pension scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Equality, diversity and inclusion and human rights

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. This includes our commitment to meeting our duties under the Equality Act 2010, ensuring compliance with the Accessible Information Standards, implementing the Equality Delivery System 2 and our active and on-going participation in the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).

Our Equality, Diversity and Inclusion (EDI) Board provides effective governance of the EDI agenda and ensures that the Trust understands and meets its legislative, social and moral responsibilities and that EDI remains visible across the organisation.

Comprising a diverse and broad membership, including senior leaders, and reporting into the Trust Executive Group (TEG), this Board oversees all EDI work carried out in respect of workforce, patients and service delivery.

[3] www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff -and-organisations/

Assessing the organisation's impact on the environment

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

We monitor the impact of the Trust's activities on the environment and through the delivery of our Board-approved Estates Strategy we continue to invest in major infrastructure schemes which reduce energy consumption and emissions.

Our plans to help identify waste reduction opportunities, deliver financial savings and reduce carbon emissions underpin Trust strategy for development of our facilities and estate. Business plan documents describe our strategic approach to meeting our statutory and mandatory obligations in respect of sustainable development.

Emergency preparedness, resilience and response

The Trust has a key role to play in responding to large scale emergencies and ensuring it can continue to deliver high quality patient services if a major and/or business continuity incident occurs. Throughout the year the emergency planning team has helped support the leadership of the Covid-19 response, deploying knowledge and experience from previous incidents to ensure that the Trust's response was based on sound emergency planning principles. In parallel, work has continued to ensure that the Trust is adequately prepared for other events including, but not limited to, mass casualties, utility failure, seasonal demand and city-wide public events. In the likelihood of such an event, the Trust is assured that appropriate plans and systems are in place to maintain services for patients.

Review of economy, efficiency and effectiveness of the use of resources

The following processes are in place to ensure that resources are used economically, efficiently and effectively:

- Development of detailed plans through the annual planning cycle which reflect service and operational requirements, financial targets in respect of income and expenditure and capital investment and incorporate required efficiency savings.
- Monthly monitoring of delivery of the Board-approved financial plan and at Directorate level by the Finance and Performance Committee and via a performance management framework that incorporates Trust Executive Group led directorate reviews.
- Monthly reporting to the Board of Directors via its committees on key performance indicators including finance, efficiency savings, activity, capacity, quality, performance, human resource management and risk. These reports are aggregated from detailed directorate level reports which support active management of resources at operational level.

- As noted above, continued delivery of a robust performance management framework which is critical to the early identification of any variance from operational or financial plans and for ensuring effective corrective action is put in place. In giving particular attention to financially challenged directorates, support is provided internally through the performance management framework with external input as required.
- Monitoring of the use of capital resources against a Board-approved capital plan by the Capital Investment Team which reports quarterly to the Board of Directors.
- New arrangements necessitated by the Covid-19 pandemic, have generated revised national funding arrangements. In particular, control and approval of specific funding for managing the pandemic has been undertaken by the Trust's Gold Command and TEG, as supported by specific groups to review proposals and requirements from directorates.
- The Making it Better (MIB) transformation and improvement programme which aims to deliver the Trust's overall strategy, and in particular, maximise efforts on improvement and transformation to help secure improved quality and sustainable finances in a challenging context. A key element of this programme is the development of information and performance management systems, including use of the national Model Hospital and Getting it Right First Time (GIRFT) metrics.
- A planned, systematic approach to improving organisational effectiveness through the alignment of strategy, people and processes. This has brought together a number of workstreams including equality, diversity and inclusion activities, service improvement, leadership and development and workforce redesign to form an Organisational Development function which the Trust recognises as being key to supporting the delivery of transformation.
- The Trust continues to work with The Health Foundation and other partners on programmes designed to build quality improvement and leadership skills and deliver improvements, such as the Flow Coaching Academy (FCA) and Microsystems Coaching Academy (MCA). The training elements of these programmes have been paused in the past year due to the Covid-19 pandemic. However, trained FCA and MCA coaches and the methodology have been instrumental in helping the Trust deliver changes in response to the crisis. This spans a wide range of services across the Trust, with examples including the expansion of Critical Care, use of an electronic referral system for Cancer pathways and the establishment of the Long Covid hub. The training elements of these programmes will resume in 2021.
- The wider use of national and peer benchmarking to ensure best value for money in delivery of services by informing and guiding service redesign,

leading to improvements in service quality and patient experience, as well as financial performance.

- Development of service line reporting (SLR) and patient level costing systems to better understand income and expenditure, therefore facilitating improved financial and operational performance. By also feeding into performance management and budget setting, SLR informs the development of action plans to address deviation from directorate financial plans.
- Assessment of efficiency schemes for their impact on quality as part of a formal quality impact assessment process.

All of these arrangements and initiatives are underpinned by the Trust's Scheme of Reservation and Delegation of Powers approved by the Board of Directors setting out the decisions, authorities and duties delegated to officers of the Trust, and by the Trust's Standing Financial Instructions detailing the financial responsibilities, policies and procedures adopted by the Trust. These are designed to ensure that an organisation's transactions are carried out in accordance with the law, government policy and good practice in order to achieve probity, accuracy, economy, efficiency and effectiveness.

The Board of Directors has gained assurance from the Audit Committee and the Finance and Performance Committee in respect of financial and budgetary management across the organisation. The Audit Committee receives, as standing items on its agenda, reports regarding losses, special payments and compensations, write-off of bad debts and contingent liabilities.

The Trust also makes use of both internal and external audit functions to support governance arrangements, deliver economic, efficient and effective use of resources and ensure that controls are effective. Internal audit continues to review systems and processes in place during the year and publishes reports detailing specific actions to ensure the economy, efficiency and effectiveness of the use of resources is maintained. The outcome of these reports and the recommendations therein are also graded according to their perceived level of risk to the organisation, therefore assisting prioritisation of management action.

During 2020/21 these have included internal audit reports on mobile working, integrity of the general ledger and financial reporting, decontamination contract management, absence data, use of electronic prescribing, data security standards and patient safety – serious incident / never event actions. These have all been reported to the Audit Committee.

In July 2020 the Audit Committee was asked to approve changes to the 2020/21 Internal Audit Plan to reflect the significant impact of the Covid-19 pandemic on the Trust's risk environment. These changes followed recommendation from the Trust Executive Group and were on the basis that a number of reviews in the original plan were no longer regarded to be a priority, while additions to the plan were requested

to reflect Covid-specific risks. The four reviews added to the plan were a review of a sample of the Covid costs, a review of PPE ordering, receipting and payment, a review of the Trust's incident command structure and a review of absence data reporting during the pandemic. Key findings provide assurance around the controls in place during the Covid-19 pandemic and are feeding into the Trust's ongoing response.

Assurance around the accuracy of data

Quality of performance information

The Trust's Data Quality Steering Group ensures a continued focus on data quality issues. In setting the direction of the Trust's Data Quality Programme and overseeing its delivery, this group receives regular progress reports from the Data Quality Operational Group and monitors Trust performance against the national Data Quality Maturity Index (DQMI).

The Group promotes whole organisation engagement in good data quality, receives and approves remedial action plans where lapses in data quality have occurred, and monitors action plan progress and effectiveness. Reporting into TEG, the Group undertakes regular reviews of strategic risks associated with data quality and escalates these as necessary.

Reviews of data quality and the accuracy, validity and completeness of Trust performance information are also considered by the Audit Committee through in-year review work undertaken by internal audit. During 2020/21 there has been focus within the internal audit plan on specific areas of data quality including a review of staff absence data, accuracy and validity checks on payroll data and a review of financial systems in respect of fixed assets, general ledger, treasury and cash management.

Programmes to improve data quality

The Trust has a number of programmes in place to improve data quality. These include:

- A well-established Electronic Patient Record and Data Quality Team to support and drive forward a coordinated data quality agenda across the organisation.
- Reporting dashboards to support improvement to data quality, including the Administrative Patient Safety Dashboard.
- Integration of Trust systems trainers within the performance and information function, to support users in learning from errors, and to further improve training to focus on data quality.

- Launch of the Administrative Profession Programme which aims to ensure all those undertaking administrative functions are suitably trained and supported. This includes standardisation of procedures, and availability of standard operating procedures for all tasks.

The Trust has strong governance arrangements in place for the management and oversight of elective waiting time data. The Activity Delivery Group meets on a monthly basis to review performance, service themes and data validation. A performance report, supported by operational reports, details the activities underway to ensure that elective waiting time data is accurate. Assurance is provided to the Waiting Times Performance and Caseload Group which also meets monthly.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Healthcare Governance Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The system of internal control has been reviewed and modified in the past year. The Trust committee structure provides balance between the three areas of quality, finance and performance management. Internal audit has been routinely used to clarify issues where assurance is required.

In accordance with NHS internal audit standards, the Head of Internal Audit is required to provide an overall annual opinion statement to the Trust, based upon, and limited to the work performed, on the overall adequacy and effectiveness of the Trust's risk management, control and governance processes. This is one component that is taken into account in making this Annual Governance Statement.

The Trust has received a statement from its internal auditors that, based on work undertaken in 2020/21, a significant opinion can be given that there is generally a sound framework of governance, risk management and control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. While providing significant assurance on the Trust's first follow up position, the statement acknowledges the impact that Covid-19 has had on this and

notes that this will continue to be monitored in 2021/22 to evaluate the progress being made to achieve an improved first follow up position.

During 2020/21, 13 internal audit reports have been reported to the Audit Committee. Two high risks related to security management have been identified from internal audit reports issued in 2020/21. A review of security management arrangements was not able to evidence clear documentation and escalation of the risks facing the service. The Trust has now ensured that the risks facing the security service are recorded within Datix and that the Annual Security Report will both report on these and be presented in a timely manner.

The Head of Internal Audit opinion statement also references a review of risk management arrangements undertaken in quarter four 2020/21. This review noted examples where arrangements for risk management within corporate directorates could be strengthened. Focus will be placed by the Trust during 2021/22 on ensuring that all directorates, clinical and corporate, embed arrangements for managing risks in line with the Framework for Risk Management and the Healthcare Governance Arrangements Policy and Framework for Delivery.

In considering the internal audit statement and on presentation with internal audit reports across the course of the year, members of the Audit Committee have noted two internal audit reports issued with limited assurance opinions. Recommendations within the reports are welcomed by members of the Trust Executive Group (TEG). Focus continues to be placed on tracking actions against recommendations through reports submitted to the Audit Committee and the reporting arrangements in place across the committee structure supports the escalation of matters between committees.

Internal audit work has been supplemented by the external audit reports which provide assurance on the Trust's arrangements for achieving economy, efficiency and effectiveness in its use of resources as part of the value for money element of its annual audit work.

The Board of Directors also received assurances on the use of resources from outside agencies including NHS England and NHS Improvement (NHSE/I) and the CQC. NHSE/I require the Trust to self-assess on a monthly basis.

My review is also informed by:

- the Integrated Risk and Assurance Report (IRAR)
- regular executive reporting to Board of Directors and escalation processes through the Board committees
- audit reports prepared independently by both the internal and external audit agencies. In particular, the ISA260 Audit Completion Report produced by Mazars LLP, our external auditor

- the published results of the quarterly performance management processes undertaken by NHSE/I under the Single Oversight Framework including the Trust's quarterly risk ratings and segmentation
- the Trust's compliance with annual performance indicators published by the Department of Health and Social Care
- ongoing compliance with CQC fundamental standards for all regulated activities across all Trust sites, as part of the registration process and reports on its visits and inspections, including the inspection report following their announced visit in June 2018
- external visits, inspections, accreditations and peer reviews
- clinical audit reports
- investigation reports and action plans following Serious Incidents and learning events and deep dive reviews
- user feedback such as monitoring of patient experience, complaints and claims
- national Patient Survey results including the Friends and Family Test
- the results of the NHS Staff Survey

Conclusion

The system of internal control has been in place in Sheffield Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2021 and up to the date of approval of the Annual Report and Accounts.

In summary, I am assured that the NHS Foundation Trust has an overall sound system of internal control in place, which is designed to manage the key organisational objectives and minimise the NHS Foundation Trust's exposure to risk. There are no significant control issues identified; however, actions are in place to address recommendations for improvement to this system made within internal audit reports issued with a limited assurance opinion and also to address the findings of recent CQC unannounced inspection and review work. We also continue to review and update the governance assurance processes to further strengthen arrangements to ensure our services are well-led. The Board of Directors is committed to continuous improvement and enhancement of the system of internal control.

Kirsten Major,

Chief Executive

11 June 2021

Independent auditor's report to the Council of Governors of Sheffield Teaching Hospitals NHS Foundation Trust

Report on the audit of the financial statements

Opinion on the financial statements

We have audited the financial statements of Sheffield Teaching Hospitals NHS Foundation Trust ('the Trust') for the year ended 31 March 2021 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual 2020/21 as contained in the Department of Health and Social Care Group Accounting Manual 2020/21, and the Accounts Direction issued under the National Health Service Act 2006.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2021 and of the Trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2020/21; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report.

Other information

The Directors are responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our

opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We are also required to consider whether we have identified any inconsistencies between our knowledge acquired during the audit and the Directors' statement that they consider the Annual Report is fair, balanced and understandable and whether the Annual Report appropriately discloses those matters that we communicated to the Audit Committee which we consider should have been disclosed.

We have nothing to report in these regards.

Responsibilities of the Accounting Officer for the financial statements

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

The Accounting Officer is required to comply with the Department of Health and Social Care Group Accounting Manual 2020/21 and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another entity. The Accounting Officer is responsible for assessing each year whether or not it is appropriate for the Trust to prepare financial statements on the going concern basis and disclosing, as applicable, matters related to going concern.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Based on our understanding of the Trust, we identified that the principal risks of non-compliance with laws and regulations related to the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), and we considered the extent to which non-compliance might have a material effect on the financial statements.

We evaluated the Accounting Officer's incentives and opportunities for fraudulent manipulation of the financial statements (including the risk of override of controls) and determined that the principal risks were related to posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates and significant one-off or unusual transactions.

Our audit procedures were designed to respond to those identified risks, including non-compliance with laws and regulations (irregularities) and fraud that are material to the financial statements. Our audit procedures included but were not limited to:

- discussing with management and the Audit Committee the policies and procedures regarding compliance with laws and regulations;
- communicating identified laws and regulations throughout our engagement team and remaining alert to any indications of non-compliance throughout our audit; and
- considering the risk of acts by the Trust which were contrary to applicable laws and regulations, including fraud.

Our audit procedures in relation to fraud included but were not limited to:

- making enquiries of management and the Audit Committee on whether they had knowledge of any actual, suspected or alleged fraud;
- gaining an understanding of the internal controls established to mitigate risks related to fraud;
- discussing amongst the engagement team the risks of fraud; and
- addressing the risks of fraud through management override of controls by performing journal entry testing.

There are inherent limitations in the audit procedures described above and the primary responsibility for the prevention and detection of irregularities including fraud rests with management and the Audit Committee. As with any audit, there remained a risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal controls.

We are also required to conclude on whether the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate. We performed our work in accordance with Practice Note 10: Audit of financial statement and regularity of public sector bodies in the United Kingdom, and Supplementary Guidance Note 01, issued by the NAO in April 2021.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We have not completed our work on the Trust's arrangements. On the basis of our work to date, having regard to the guidance issued by the Comptroller and Auditor General in April 2021, we have not identified any significant weaknesses in arrangements for the year ended 31 March 2021.

We will report the outcome of our work on the Trust's arrangements in our commentary on those arrangements within the Auditor's Annual Report. Our audit completion certificate will set out any matters which we are required to report by exception.

Responsibilities of the Accounting Officer

The Chief Executive as Accounting Officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the Trust's use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Auditor's responsibilities for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by Schedule 10(1) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our work in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 2021.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2020/21; and
- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception under the Code of Audit Practice

We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the NHS Foundation Trust Annual Reporting Manual 2020/21; or
- the Annual Governance Statement is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements; or
- we refer a matter to the regulator under Schedule 10(6) of the National Health Service Act 2006; or
- we issue a report in the public interest under Schedule 10(3) of the National Health Service Act 2006.

We have nothing to report in respect of these matters.

Use of the audit report

This report is made solely to the Council of Governors of Sheffield Teaching Hospitals NHS Foundation Trust as a body in accordance with Schedule 10(4) of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust as a body for our audit work, for this report, or for the opinions we have formed.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed the work necessary to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness is its use of resources and issued our assurance statement to the group auditor in respect of the Trust's consolidation schedules.

Mark Dalton, Key Audit Partner

For and on behalf of Mazars LLP

5th Floor, 3 Wellington Place

Leeds LS1 4AP

11 June 2021

Audit Completion Certificate issued to the Council of Governors of Sheffield Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2021

In our auditor's report dated 11 June 2021 we explained that the audit could not be formally concluded until we had completed the work necessary to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness is its use of resources. In addition, we were not able to conclude our audit as we had not completed work required to report to the National Audit Office as group auditor of the Consolidated Provider Account.

This work has now been completed.

No matters have come to our attention since 11 June 2021 that would have a material impact on the financial statements on which we gave our unqualified opinion.

The Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in April 2021, we have identified the following significant weakness in the Trust's arrangements for the year ended 31 March 2021:

Significant weakness in arrangements	Recommendation
Care Quality Commission (CQC) inspection of maternity services In March 2021, the CQC carried out an unannounced focused inspection of the Trust's maternity services. In their report, published in June 2021, the CQC rated the service as 'inadequate' and set out a number of areas for improvements that the Trust must address to comply with the conditions of registration set by the CQC. In our view, the inspection outcome and the matters raised by the CQC represent a significant weakness in arrangements in relation to: • Governance - how the Trust ensures that it makes informed decisions and properly manages its risks; and • Improving economy, efficiency and effectiveness – how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.	The Trust should ensure it embeds and sustains the action plans that it has put in place to address the patient care issues identified by the CQC. In particular, it should ensure that robust monitoring and reporting processes are maintained, and that challenge, scrutiny and escalation arrangements drive the required improvements and sustain the progress made to date in implementing the actions to address the issues raised by the CQC.

Certificate

We certify that we have completed the audit of Sheffield Teaching Hospitals NHS Foundation Trust in accordance with the requirements of chapter 5 of part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Mark Dalton, Key Audit Partner

For and on behalf of Mazars LLP

5th Floor, 3 Wellington Place

Leeds LS1 4AP

20 July 2021

Financial Accounts 2020-21

Foreword to the accounts

Sheffield Teaching Hospitals NHS Foundation Trust

These accounts for the year ended 31 March 2021 have been prepared by the Sheffield Teaching Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of schedule 7 of the National Health Service Act 2006 in the form which Monitor, operating as NHS Improvement, has, with the approval of the Secretary of State for Health, directed, and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of that Act.

After making enquiries, the Directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Signed

Kirsten Major
Chief Executive
11 June 2021

Statement of comprehensive income for the year ending 31 March 2021

	Note	2020/21 £'000	2019/20 £'000
Income from patient care activities	3.1	1,086,427	1,019,202
Other operating income	3.1	236,557	177,863
Operating Expenses from continuing operations	4.1	(1,301,215)	(1,203,960)
OPERATING (DEFICIT) / SURPLUS		**21,769**	**(6,895)**
Finance Costs:			
Finance income	7.1	0	881
Finance expense - financial liabilities	7.2	(2,804)	(2,946)
Finance income - unwinding of discount on provisions	19	32	16
Public Dividend Capital dividend expense	29	(5,666)	(8,032)
Net Finance Costs		**(8,438)**	**(10,081)**
Gains on disposal of assets		175	408
SURPLUS / (DEFICIT) FROM CONTINUING OPERATIONS		**13,506**	**(16,568)**
Other comprehensive income:			
Impairments		193	(3,235)
Revaluation		3,113	1,094
Other reserve movements		0	0
TOTAL COMPREHENSIVE (EXPENSE) / INCOME FOR THE YEAR		**16,812**	**(18,709)**

The notes on pages 121 to 155 form part of these accounts.

All income and expenditure is derived from continuing operations, and the deficit is attributable to the owners of the Trust (the Taxpayer).

Statement of financial position

	Note	31 March 2021 £'000	31 March 2020 £'000
Non-current assets:			
Intangible assets	8.1 & 8.2	4,486	6,858
Property, plant and equipment	9.2	411,094	390,019
Investments	11	0	0
Trade and other receivables	13.2	6,512	6,343
Total non-current assets		**422,092**	**403,220**
Current assets:			
Inventories	12.1	14,113	14,672
Trade and other receivables	13.1	22,705	64,645
Current asset investments	14	0	0
Cash	21	186,253	90,775
Total current assets		**223,071**	**170,092**
Current liabilities:			
Trade and other payables	15.1	(139,955)	(110,752)
Borrowings	16.1	(2,479)	(2,465)
Provisions due within one year	19	(5,745)	(2,974)
Other liabilities	17.1	(20,773)	(19,539)
Total current liabilities		**(168,952)**	**(135,730)**
Total assets less current liabilities		**476,211**	**437,582**
Non-current liabilities:			
Borrowings	16.2	(32,616)	(35,075)
Provisions due after one year	19	(3,985)	(3,127)
Other liabilities	17.2	(2,724)	(1,324)
Total non-current liabilities		**(39,325)**	**(39,526)**
TOTAL ASSETS EMPLOYED		**436,886**	**398,056**
FINANCED BY:			
Taxpayers' equity			
Public Dividend Capital		353,652	331,634
Revaluation reserve	20	37,439	35,179
Income and expenditure reserve		45,795	31,243
TOTAL TAXPAYERS' EQUITY		**436,886**	**398,056**

The financial statements on pages 116 to 155 were approved by the Board on 25 May 2021 and were signed on behalf of the Board by

Kirsten Major, Chief Executive

Date: 11 June 2021

Statement of changes in Taxpayers' Equity

	Note	Total	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
		£'000	£'000	£'000	£'000
Taxpayers' Equity at 1 April 2020		398,056	331,634	35,179	31,243
Surplus for the year		13,506			13,506
Transfers between reserves	20	0		(1,046)	1,046
Impairments	20	193		193	
Revaluation gains on property, plant and equipment	20	3,113		3,113	
Public Dividend Capital received		22,018	22,018		
Other Reserve Movements		0	0	0	0
Taxpayers' Equity at 31 March 2021		**436,886**	**353,652**	**37,439**	**45,795**
Taxpayers' Equity at 1 April 2019		414,691	329,560	38,370	46,761
(Deficit) for the year		(16,568)			(16,568)
Transfers between reserves	20	0		(1,050)	1,050
Impairments	20	(3,235)		(3,235)	
Revaluation gains on property, plant and equipment	20	1,094		1,094	
Public Dividend Capital received		2,074	2,074		
Other Reserve Movements		0	0	0	0
Taxpayers' Equity at 31 March 2020		**398,056**	**331,634**	**35,179**	**31,243**

Statement of Cash Flows

	Note	2020/21 £'000	2019/20 £'000
Cash flows from operating activities			
Operating surplus / (deficit) from continuing operations		21,769	(6,895)
Non-cash income and expenditure:			
Depreciation and amortisation	4.1	23,420	23,295
Net Impairments	4.1	5,620	23,064
Income recognised in respect of capital donations (cash and non-cash)	3.1	(2,095)	(1,013)
Decrease / (Increase) in Trade and other Receivables		42,251	3,532
(Increase) in Inventories		559	(860)
Increase in Trade and other Payables		25,151	5,208
Increase in Other Liabilities		2,634	2,828
Increase in Provisions		3,661	159
Other movements in operating cashflows		(218)	(367)
Net cash generated from / (used in) operations		**122,752**	**48,951**
Cash flows from investing activities:			
Interest received		28	909
Purchase of investments		0	(595,000)
Proceeds from settlement of investments		0	595,000
Purchase of intangible assets		(206)	(865)
Purchase of Property, Plant and Equipment		(38,302)	(42,300)
Sales of Property, Plant and Equipment		158	408
Receipt of Cash Donations to purchase capital assets		218	367
Net cash generated / (used in) investing activities		**(38,104)**	**(41,481)**
Cash flows from financing activities:			
Public Dividend Capital received		22,018	2,074
DHSC Loans repaid		(1,445)	(1,445)
Capital element of finance lease rental payments		(531)	(417)
Capital element of Private Finance Initiative obligations		(468)	(574)
Interest on DHSC loans		(861)	(935)
Interest element of finance lease		(48)	(65)
Interest element of Private Finance Initiative obligations		(1,896)	(1,949)
Public Dividend Capital Dividend paid		(6,248)	(7,865)
Cash flows from other financing activities		309	448
Net cash generated from / (used in) financing activities		**10,830**	**(10,728)**
Increase / (Decrease) in cash and cash equivalents		**95,478**	**(3,258)**
Cash and Cash equivalents at 1 April	21	90,775	94,033
Cash and Cash equivalents at 31 March	21	**186,253**	**90,775**

Accounting policies for the year ending 31 March 2021

1. Accounting policies

The Secretary of State for Health/NHS Improvement in exercising the statutory functions conferred on Monitor/NHS England, has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DHSC GAM 2020/21, issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the DHSC GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the NHS Foundation Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

The Trust's annual report and accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

1.2 Accounting convention

These accounts have been prepared under the historical cost convention, modified to account for the revaluation of property, plant and equipment, intangible assets and certain financial assets and financial liabilities.

1.3 Basis of consolidation

With effect from 1 April 2017, Sheffield Hospitals Charity became an independent charity, rather than being an NHS Charity. The Trust has established that it is not a corporate Trustee of any of its supporting or linked Charities and does not have the power to exercise control so as to obtain economic benefits, meaning consolidation is not appropriate. Additionally the transactions and balances are immaterial in the context of the Trust operations.

The Trust has a number of minor interests (approx. £500k) in the following entities, none of which are material to the Trust's operations, and are thus not consolidated on the grounds of materiality:

Name	Nature of Relationship
Epaq Systems Ltd	Minor share-holding in low net worth company
Zilico	Minor share-holding in low net worth company
Elaros 24/7 Ltd	Minor share-holding in low net worth company
Better Hygiene Ltd (formerly Wetwash Ltd)	Minor share-holding in low net worth company
Medipex Ltd	No return to the Trust
Legacy Park Ltd	No return to the Trust

1.4 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.4.1 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

• Basis of consolidation/Interests in other entities – see note 1.3.

1.4.2 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

• Plant, property and equipment valuations and useful economic lives

The Trust has used valuations carried out at 31 March 2020 by its expert valuers to determine the value of property. These property valuations and useful lives are based on the Royal Institution of Chartered Surveyors valuation standards insofar as these are consistent with the requirements of HM Treasury, the National Health Service and the Department of Health and Social Care. Further details are provided in paragraph 1.11 and note 9.5 of the accounts.

Depreciation of equipment is based on asset lives, which have been estimated upon recognition of the assets. Managers have adjusted estimated lives at the end of the accounting period, where their estimate of useful life is significantly different to the original. The estimate of asset lives may differ to the actual period the Trust utilises the asset but any difference would not be material.

Depreciation of equipment is based on asset lives, which have been estimated upon recognition of the assets. Managers have adjusted estimated lives at the end of the accounting period, where their estimate of useful life is significantly different to the original. The estimate of asset lives may differ to the actual period the Trust utilises the asset but any difference would not be material.

• Revenue estimates

Achieving early closure of accounts means that the accounts must be prepared before the normal cycle for contract income is complete. Contract income includes some estimated values and assessment of income risk based on agreements with the main commissioning bodies. Actual amounts may differ from the estimate depending on actual activity levels, but not materially so. Further details are provided in paragraph 1.5.

• Estimation of payments for the PFI and service concession assets, including finance costs

The assets and liabilities relating to the PFI scheme have been brought onto the Statement of Financial Position based on estimations from the Department of Health and Social Care's financial model as required by the Department of Health and Social Care guidance. The models also provide estimates for interest payable and contingent rent as disclosed in note 18 of the accounts.

• Impairment of receivables

The Trust is required to judge when there is sufficient evidence to impair individual receivables; this is undertaken on the aged profile and class of the receivable. The Trust adopts a prudent policy of increasing the expected credit loss, with the increasing ageing of the receivable. The Trust makes every effort to collect the debt, even when it has been impaired, and only writes off the debt as a final course of action after all possible collection efforts have been made. The actual level of debt written off may be different to that which had been judged as impaired, but not materially so. Further details are provided in paragraph 1.24 and note 13.3 of the accounts.

• Provisions

Provisions are a matter of judgement, with a best estimate made based information available at the time. Once realised, provisions can be different to the original estimate, but not materially so. Further details are provided in paragraph 1.20 and note 19 of the accounts.

1.5 Revenue

In the application of IFRS 15 (Revenue from contracts with customers) a number of practical expedients offered in the Standard have been employed. These are as follows;

- The Trust will not disclose information regarding the performance obligations part of a contract that has an original expected duration of one year or less.
- The Trust is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in the Standard, where the right to consideration corresponds directly with value of the performance completed to date.
- The FReM has mandated the exercise of the practical expedient offered in the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

Revenue from NHS contracts

The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

2020/21

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at an Integrated Care System level. The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

Comparative period (2019/20)

In the comparative period (2019/20), the Trust's contracts with NHS commissioners included those where the Trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.6 Employee benefits

1.6.1 Short-term employee benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including non-consolidated performance pay earned but not yet paid. The cost of annual leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.6.2 Retirement benefit costs NHS pensions

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including non-consolidated performance pay earned but not yet paid. The cost of annual leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years with approximate assessments in intervening years.

The valuation of the scheme liability as at 31 March 2021, is based on valuation data as at 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay, and the Scheme Regulations were amended accordingly.

Details of the benefits payable under, and rule of, the NHS Pension Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

1.7 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.8 Grants payable

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the Trust recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.9 Value Added Tax (VAT)

Most of the activities of the NHS Foundation Trust are outside the scope of VAT.

Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.10 Corporation Tax

Foundation Trusts currently have a statutory exemption from Corporation Tax on all their activities.

1.11 Property, plant and equipment

1.11.1 Recognition

Property, Plant and Equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to the Trust;
- it is expected to be used for more than one financial year; and
- the cost of the item can be measured reliably, and either
- the item individually has a cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

Property, plant and equipment assets are also capitalised where they form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their individual useful economic lives.

1.11.2 Measurement

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus (with no plan to bring it back into use) are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost, modern equivalent asset basis.

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the service being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset, and thereafter to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income/net expenditure in the Statement of Comprehensive Income.

1.11.3 Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Useful economic lives of property, plant and equipment

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives is set out in note 9.5 to the accounts.

1.12 Intangible assets

1.12.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

Expenditure on research is not capitalised; it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it, and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.12.2 Measurement

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria for recognition are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

Revaluations and impairments are treated in the same manner as for Property, Plant and Equipment.

Useful economic lives of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives is shown in note 8.4 to the accounts.

1.13 Depreciation, amortisation and impairments

Freehold land, assets under construction or development and assets held for sale are not depreciated/amortised.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible assets, less any residual value, on a straight-line basis over their estimated useful lives. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life, unless the Trust expects to acquire the asset at the end of the lease term, in which case the asset is depreciated in the same manner as for owned assets.

At each financial year end, the Trust checks whether there is any indication that its property, plant and equipment or intangible assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year end.

Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure.

Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure..

1.14 Donated assets

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.15 Government grant funded assets

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.16 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.16.1 The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges

and reduction of the lease obligation to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in the Statement of Comprehensive Income.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.16.2 The Trust as lessor

A lessor shall classify each of its leases as an operating or finance lease. A lease is classified as a finance lease when the lease substantially transfers all the risks and rewards incidental to ownership of an underlying asset. Where substantially all the risks and rewards are not transferred, a lease is classified as an operating lease.

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Income from operating leases is recognised on a straight-line or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

1.17 Private Finance Initiative (PFI) transactions

PFI transactions that meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17, the underlying assets are recognised as Property, Plant and Equipment at their current value, together with an equivalent finance lease liability.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

- payment for the fair value of services received
- repayment of the finance lease liability, including finance costs, and
- payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

1.17.1 Services received

The cost of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

1.17.2 PFI assets, liabilities and finance costs

The PFI assets are recognised as property, plant and equipment when they come into use. The assets are measured initially at fair value or, if lower, at the present value of the minimum lease payments, in accordance with the principles of IAS 17. Subsequently, the assets are measured at current value in existing use.

A PFI liability equal to the capital value of the contract is recognised at the same time as the PFI assets are recognised. This does not include service elements and interest charges within the PFI contract which are expensed in accordance with IFRIC12 as adapted and interpreted by the FReM and as detailed below. The liability is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the contract to the opening PFI liability for the period, and is charged to "finance costs" within the Statement of Comprehensive Income.

An element of the annual unitary payment is therefore allocated as a financing cost when repaying the PFI liability over the life of the contract.

The element of the annual unitary payment increase due to cumulative indexation is firstly apportioned to service charges and life cycle costs and the residual amount is treated as contingent rent and is expensed as incurred..

1.17.3 Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at cost.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term accrual or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised.

The deferred income is released to operating income over the shorter of the remaining contract period or the useful economic life of the replacement component..

1.18 Inventories

Inventories are valued at the lower of cost and net realisable value, using the First In, First Out (FIFO) cost formula.

In 2020/21, the Trust received and consumed inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt and consumption of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

1.19 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.20 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of negative 0.95% (2019/20: negative 0.50%) in real terms.

All general provisions are subject to four separate (nominal) discount rates according to the expected timing of cash-flows from the Statement of Financial Position date: :

Period	Period Definition for expected cash flows	2020/21 Nominal Rate (%)	2019/20 Nominal Rate (%)
Short term	Up to and including 5 years	-0.02%	+0.51%
Medium term	Over 5 years and up to and including 10 years	+0.18%	+0.55%
Long term	Over 10 years and up to and including 40 years	+1.99%	+1.99%
Very long term	Exceeding 40 years	+1.99%	+1.99%

1.21 Clinical negligence costs

NHS Resolution (the trading name of the NHS Litigation Authority NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is

administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust.

The total value of clinical negligence provisions carried by NHS Resolution on behalf of the NHS Foundation Trust is disclosed at note 19, but is not recognised in the Trust's accounts.

1.22 Non clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.23 Contingent liabilities and contingent assets

A contingent liability is:

- a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust; or
- a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably.

A contingent liability is disclosed (in note 24.1), unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed (in note 24.2) where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.24 Financial assets

Recognition and de-recognition, measurement and classification

Financial assets are recognised when the Trust becomes party to the contractual provision of the financial instrument or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or when the asset has been transferred and the Trust has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

Financial assets are initially recognised at fair value plus or minus directly attributable transaction costs for financial assets not measured at fair value through profit or loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices where possible, or by valuation techniques.

Financial assets are classified into the following categories: financial assets at amortised cost, financial assets at fair value through other comprehensive income, and financial assets at fair value through profit and loss. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.24.1 Financial assets at amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is to hold financial assets in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables, loans receivable, and other simple debt instruments.

After initial recognition, these financial assets are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset..

1.24.2 Financial assets at fair value through other comprehensive income

Financial assets measured at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

1.24.3 Financial assets at fair value through profit and loss

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

1.24.4 Impairment

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the Trust recognises a loss allowance representing expected credit losses on the financial instrument.

The Trust adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1).

Invoiced contract receivables and Non-invoiced contract receivables are largely with other public sector bodies where the risk of credit losses are low and where income and receivable balances are subject to nationally agreed processes and timetables as outlined below. Credit losses on other contract assets, which are not material, are assessed on a case by case basis as relevant and appropriate.

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.25 Financial liabilities

Recognition and de-recognition, and measurement

Financial liabilities are recognised when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been extinguished – that is, the obligation has been discharged or cancelled or has expired.

1.25.1 Financial liabilities at fair value through profit and loss

Derivatives that are liabilities are subsequently measured at fair value through profit or loss, Embedded derivatives that are not part of a hybrid contract containing a host that is an asset within the scope of IFRS 9 are separately accounted for as derivatives only if their economic characteristics and risks are not closely related to those of their host contracts, a separate instrument with the same terms would meet the definition of a derivative, and the hybrid contract is not itself measured at fair value through profit or loss.

1.25.2 Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability. In the case of DHSC loans, that would be the nominal rate charged on the loan.

1.26 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital is a type of public sector equity finance, which represents the Department of Health and Social Care's investment in the Trust. HM Treasury has determined that, being issued under statutory authority rather than under contract, PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health and Social Care as PDC dividend. The charge is calculated at the real rate set by the Secretary of State with the consent of HM Treasury (currently 3.5%) on the average relevant net assets of the Trust. Relevant net assets are calculated as the value of all assets less all liabilities, except for:

- donated assets (including lottery funded assets), grant funded and assets purchased in the response to COVID-19
- average daily cash balances held with the Government Banking Service (GBS) and National Loans Fund (NLF) deposits (excluding cash balances held in GBS accounts that relate to a short term working capital facility)
- any PDC dividend balance receivable or payable.

The average relevant net assets are calculated as a simple average of opening and closing relevant net assets.

In accordance with the requirements laid down by the Department of Health and Social Care, the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts..

1.27 Foreign currencies

The Trust's functional currency and presentational currency is pounds sterling, and figures are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling (the functional currency) at the spot exchange rate on the date of the transaction.

1.28 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in note 27 to the accounts.

1.29 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accruals basis with the exception of provisions for future losses.

1.30 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

1.31 Accounting standards that have been issued but have not yet been adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2020/21. These Standards are still subject to HM Treasury FReM adoption.

1.31.1 IFRS 16 Leases

IFRS 16 Leases will replace IAS 17 Leases, *IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 1.27% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2022 during November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable. However, the trust does not expect this standard to have a material impact on non-current assets, liabilities and depreciation.

1.31.2 IFRS 17 Insurance Contracts

IFRS 17 *Insurance Contracts* – Application required for accounting periods beginning on or after 1 January 2023, with adoption by the FReM from 1 April 2023: early adoption is not therefore permitted. The Trust does not expect the adoption of this standard to have a material impact on the Accounts of the Trust.

2. Segmental analysis

The Trust has determined that the Chief Operating decision maker (as defined by IFRS8: Operating Segments) is the Board of Directors, on the basis that all strategic decisions are made by the Board.

The Board reviews the operating and financial results of the Trust on a monthly basis and considers the position of the Trust as a whole in its decision making process, rather than as individual components which comprise the total, in terms of allocating resources. Consequently the Board of Directors considers that all the Trust's activities fall under the single segment of provision of healthcare, and no further segmental analysis is therefore required.

3. Income

3.1 Operating income from activities: Analysis by nature

	Sub-note	2020/21		2019/20	
		£'000	£'000	£'000	£'000
Operating income from activities					
Elective income			0		180,952
Non Elective income			0		219,557
Outpatient income			0		127,316
A&E Income			0		25,396
Other NHS Clinical income	(1)		0		366,237
Contract income (2020/21 under COVID-19 block contracts)			803,149		0
High Cost Drugs			165,662		0
Other NHS Clinical income not included within COVID-19 block contracts			15,220		0
Income re Community Services			69,781		67,880
Private Patient Income			2,077		3,328
Additional Pension Contribution	(2)		30,538		28,536
Total operating income from activities			**1,086,427**		**1,019,202**
Other operating income					
Research and development					38,564
Education and training					52,643
Non-patient care services to other bodies					56,507
COVID-19 reimbursement & top up funding		63,709		0	
COVID-19 consumables donated by DHSC		11,968		0	
COVID-19 response: DHSC donated capital equipment		1,711		0	
COVID-19 response: DHSC donated revenue equipment		103		0	
			77,491		0
Provider Sustainability Funding income			0		15,440
Received from other bodies: Cash donations for capital acquisitions	(3)		69		160
Received from NHS Charities: Receipt of grants/donations for capital acquisitions	(3)		149		207
Received from other bodies: Receipt of grants/donations for capital acquisitions	(3)		166		646
Other	(3) & (4)		5,860		12,645
Operating lease income	Note 3.4		510		1,051
Total other operating income			**236,557**		**177,863**
Total operating income			**1,322,984**		**1,197,065**

Sub-notes

(1) 2019/20 Other NHS Clinical Income consists mainly of high cost drugs, non-drugs cost per case income, critical care income, COVID-19 income and sundry block contract income across a range of specialities

(2) A revaluation of public sector pensions schemes during 2019/20 resulted in a 6.3% increase (14.38% to 20.68% including administration levy) in the employer contribution rate for the NHS Pensions Scheme. A transitional approach was agreed whereby an employer rate of 20.68% applies from 1 April 2019.

However during 2019/20 and 2020/21 the NHS Business Service Authority collected only 14.38% from employers. Central payments have been made by NHS England and the Department of Health and Social Care for their respective proportions of the outstanding 6.3% on local employers' behalf and income has been uplifted to show these contributions to Trust expenses.

(3) Other operating income, with the exception of income received from NHS charities and other bodies, and 'Other' is contract revenue as defined under IFRS15

(4) Other Operating Income 'Other' consists of sundry income from the provision of various facilities to staff, patients and public on STH sites. The largest individual components relate to the provision of catering and nursery facilities. 2019/20 income also included car parking income, which was much reduced during the 2020/21 pandemic year.

3.2 Operating income from activities: Analysis by source

		2020/21 £'000	2019/20 £'000
Clinical Commissioning Groups and NHS England		1,074,219	1,004,415
NHS Foundation Trusts		16	82
NHS Trusts		0	1
Department of Health and Social Care (DHSC)		1	710
Local Authorities		4,251	5,095
NHS Other		2,570	2,149
Non NHS: Private patients		1,280	2,426
Non NHS: Overseas patients (non-reciprocal)		797	902
NHS injury scheme (formerly the Road Traffic Act Scheme)		3,033	3,029
Non NHS: Other	(5)	260	393
Total operating income from activities by source		**1,086,427**	**1,019,202**

(5) Non NHS Other income from activities comprises income from prescription charges.

3.3 Income from Commissioner Related Services

Commissioner Related Services for the year totalled £1,139,349k (2019/20 £1,066,217k). Non Commissioner Related Services were £183,635k (2019/20 £130,848k).

3.4 Operating lease income

	2020/21 £'000	2019/20 £'000
Rents recognised as income in the period	510	1,051
Contingent rents recognised as income in the period	0	0
	510	**1,051**

Future minimum lease payments due	2020/21 £'000	2019/20 £'000
Re land		
- not later than one year;	37	38
- later than one year and not later than five years;	150	150
- later than five years.	679	715
Total	**866**	**903**
Re buildings		
- not later than one year;	872	763
- later than one year and not later than five years;	2,717	2,694
- later than five years.	4,412	4,893
Total	**8,001**	**8,350**
Total - all categories		
- not later than one year;	909	801
- later than one year and not later than five years;	2,867	2,844
- later than five years.	5,091	5,608
Total	**8,867**	**9,253**

3.5 Overseas Visitors (relating to patients charged directly by the Trust)

	2020/21 £'000	2019/20 £'000
Income recognised in year	797	902
Cash payments received in year (relating to invoices raised in current and previous years)	180	167
Amounts added to provision for impairment of receivables (relating to invoices raised in current and previous years)	1,708	484
Amounts written off in year (relating to invoices raised in current and previous years)	254	6

3.6 Additional Information in contract Revenue (IRFS 15) recognised for the period

	2020/21 £'000	2019/20 £'000
Revenue recognised in the reporting period that was previously included in the contract liability balance (ie release in year of deferred IRFS 15 income)	8,879	6,312

4. Operating expenses

4.1 Operating expenses: Analysis by nature:

	Sub-note	2020/21 £'000	2019/20 £'000
Purchase of Healthcare from NHS and DHSC Bodies		17,213	20,239
Purchase of Healthcare from non NHS and DHSC bodies		17,049	24,347
Staff and Executive Directors' costs	(1) & Note 5.1	786,359	727,152
Non-Executive Directors' costs		166	178
Drugs costs		184,842	167,974
Supplies and services – clinical		79,858	100,591
Supplies and services - general	(1)	52,316	8,338
Establishment		9,394	9,025
Research and Development		27,358	24,513
Transport		1,101	987
Premises		51,312	42,809
Movement in credit loss allowance		2,285	840
Change in provisions discount rate		144	239
Depreciation on property, plant and equipment		20,924	20,605
Amortisation of intangible assets		2,496	2,690
Net Impairments of property, plant and equipment	Note 7.3	5,581	23,029
Net Impairments of intangible assets	Note 7.3	39	35
Operating lease costs	Note 4.3	1,418	952
Audit services - statutory audit	Note 4.2	58	54
Other auditor remuneration - audit related assurance purposes - quality report review	Note 4.2	0	2
Clinical negligence		23,460	18,044
Legal fees		2,383	1,414
Consultancy costs		1,410	1,638
Internal audit costs		158	159
Training, courses and conferences		6,356	3,448
Redundancy		0	45
Charges to operating expenditure for on-SoFP for IFRIC 12 Schemes		664	649
Insurance		627	446
Other Services		2,918	2,930
Losses, ex gratia & special payments		475	29
Other		2,851	559
Total operating expenses		**1,301,215**	**1,203,960**

(1) Staffing costs and general supplies show significant increases over expenditure levels in the prior year, as a result of staffing and personal protective equipment needs during the COVID-19 pandemic.

4.2 Auditor's liability	2020/21 £'000	2019/20 £'000
Limitation on Auditor's liability	Unlimited	Unlimited

An analysis of the work of the Auditors and the associated fees for the respective work is included above and on page 72 of the Annual Report. Fees and Remuneration above are stated inclusive of VAT.

4.3 Arrangements containing an operating lease - current year expenditure	2020/21 £'000	2019/20 £'000
Minimum lease payments	2,248	1,450
Contingent rents	0	0
Less sub-lease payments received	(830)	(498)
Total	**1,418**	**952**

4.4 Arrangements containing an operating lease - future years' commitments	2020/21 £'000	2019/20 £'000
Future minimum lease payments due:		
Within 1 year	2,261	1,889
Between 1 and 5 years	4,930	4,002
After 5 years	505	1,086
Total	**7,696**	**6,977**

5. Staff costs

5.1 Employee expenses	Sub-note	2020/21 £'000	2019/20 £'000
Salaries and wages		622,147	569,542
Social Security Costs		53,472	49,464
Apprenticeship Levy		2,852	2,669
Employer contributions to NHSPA		69,757	65,293
Pension Cost - employer contribution paid by NHSE on providers' behalf	(1)	30,538	28,536
Other pension costs		405	400
Agency / contract staff		7,188	11,248
Total	(2)	**786,359**	**727,152**

(1) A revaluation of public sector pensions schemes during 2019/20 resulted in a 6.3% increase (14.38% to 20.68% including administration levy) in the employer contribution rate for the NHS Pensions Scheme. A transitional approach was agreed whereby an employer rate of 20.68% applies from 1 April 2019.

However during 2019/20 and 2020/21 the NHS Business Service Authority collected only 14.38% from employers. Central payments have been made by NHS England and the Department of Health and Social Care for their respective proportions of the outstanding 6.3% on local employers' behalf and expenditure has been uplifted to show these contributions to Trust expenses.

(2) The above figure of £786,359k is net of the amount of £926k (2019/20 £1,071k) in respect of capitalised salary costs included in fixed asset additions (notes 8.1 and 9.1).

Further details of staff numbers and costs can be found within the Staff Report on pages 46 to 60 of the Annual Report.

5.2 Early retirements due to ill health

	2020/21	2019/20
	Number	Number
Number of early retirements agreed on the grounds of ill health	12	13
	£'000	£'000
Cost of early retirements agreed on grounds of ill health	281	659

These costs were borne by the NHS Pensions Agency.

6. Performance on payment of debts

The Better Payment Practice Code requires the Trust to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. The Trust's performance against this code is set out below:

	2020/21	2019/20
	Number	Number
Number of non NHS invoices paid	180,455	219,424
Number of non NHS invoices paid within 30 days	176,873	211,606
Percentage of invoices paid within 30 days	98.02%	96.44%
	£'000	£'000
Value of non NHS invoices paid	465,606	453,515
Value of non NHS invoices paid within 30 days	453,573	435,759
Percentage of invoices paid within 30 days	97.42%	96.08%
Amounts included within Interest Payable (Note 7.2) arising from claims made under the Late Payment of Debts (Interest) Act 1998	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0

During the Year the Trust observed and took part in the national COVID-19 Supplier Relief initiative, whereby credit terms were reduced to seven days from invoice date, in order to help ensure liquidity and continuity of service from suppliers.

During the year the Trust did make certain payments for personal protective equipment in advance of delivery, as necessitated by circumstances, and under the relevant guidance and governance arrangements pertinent at the time. All such goods were subsequently receipted into the Trust.

7. Financing

7.1 Finance income

	2020/21	2019/20
	£'000	£'000
Bank account interest	0	550
Investment interest	0	331
Total	**0**	**881**

No investments have been made during the 2020/21 financial year, given the absence of a positive return

7.2 Finance costs – interest expense

	2020/21 £'000	2019/20 £'000
Capital loans from the Department of Health and Social Care	860	932
Finance Lease interest	48	65
Finance Costs in PFI Obligations		
Main Finance Costs	1,052	1,088
Contingent Finance Costs	844	861
Total	**2,804**	**2,946**

7.3 Impairment of assets

	2020/21 £'000	2019/20 £'000
Loss or damage from normal operations	82	326
Abandonment of assets in course of construction	150	44
Changes in market price	16,419	23,188
Reversal of impairments	(11,031)	(494)
Net Impairments charged to operating expenses	**5,620**	**23,064**

During 2020/21, the above value includes the reversal of the prior impairment charge in relation to the Hadfield block, following remedial work.

8. Intangible non-current assets

8.1 Intangible non-current assets 2020/21

	Total £'000	Intangible assets under construction £'000	Software Licenses £'000
Gross Cost at 1 April 2020	21,174	0	21,174
Additions - purchased / internally generated	147	112	35
Additions - donated	16	16	0
Impairments charged to operating expenses	(39)	(39)	0
Reclassifications	0	(89)	89
Disposals	(201)	0	(201)
Gross cost at 31 March 2020	**21,097**	**0**	**21,097**
Amortisation at 1 April 2020	14,316	0	14,316
Provided during the year	2,496		2,496
Impairments	0		0
Reversal of Impairments credited to operating expenses	0		0
Reclassification	0		0
Disposals	(201)		(201)
Amortisation at 31 March 2021	**16,611**	**0**	**16,611**
Net Book Value at 31 March 2021	**4,486**	**0**	**4,486**

8.2 Intangible non-current assets 2019/20

	Total	Intangible assets under construction	Software Licenses
	£'000	£'000	£'000
Gross cost at 1 April 2019	20,015	0	20,015
Additions - purchased / internally generated	1,181		1,181
Additions - donated	0		0
Impairments charged to operating expenses	(22)		(22)
Reclassifications	0		0
Disposals	0		0
Gross cost at 31 March 2019	**21,174**	**0**	**21,174**
Amortisation at 1 April 2019	11,613	0	11,613
Provided during the year	2,690		2,690
Impairments	13		13
Reversal of Impairments credited to operating expenses	0		0
Reclassification	0		0
Disposals	0		0
Amortisation at 31 March 2020	**14,316**	**0**	**14,316**
Net Book Value at 31 March 2020	**6,858**	**0**	**6,858**

8.3 Analysis of intangible non-current assets

	2020/21	2019/20
	£'000	£'000
Net Book Value		
- Purchased	4,486	6,857
- Donated	0	1
Total 31 March	**4,486**	**6,858**

8.4 Economic life of intangible non-current assets

	Min Life Years	Max Life Years
Software licences	5	8

9. Property, plant and equipment – Non-current assets

9.1 Property, Plant and Equipment 2020/21

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information Technology	Furniture and fittings
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Gross Cost at 1 April 2020	518,488	11,187	301,994	2,093	22,803	140,883	1,220	27,767	10,541
Additions-purchased	42,195	88	3,434	0	32,080	6,034	83	245	231
Additions-leased assets	0	0	0	0	0	0	0	0	0
Additions-donated	166	0	0	0	0	166	0	0	0
Additions-equipment donated from DHSC for COVID-19 response	1,711	0	0	0	0	1,711	0	0	0
Additions-assets purchased from cash donations	202	0	4	0	109	85	0	0	4
Impairments charged to operating expenses	(16,530)	0	(16,420)	0	(110)	0	0	0	0
Impairments charged to revaluation reserve	(31)	0	(31)	0	0	0	0	0	0
Reversal of impairments credited to operating expenses	11,031	0	11,031	0	0	0	0	0	0
Reversal of impairments credited to revaluation reserve	224	0	224	0	0	0	0	0	0
Reclassifications	0	0	25,767	0	(31,279)	4,253	0	807	452
Revaluations	2,276	346	1,930	0	0	0	0	0	0
Disposals	(8,561)	0	0	0	0	(5,855)	(78)	(1,314)	(1,314)
Cost or valuation at 31 March 2021	**551,171**	**11,621**	**327,933**	**2,093**	**23,603**	**147,277**	**1,225**	**27,505**	**9,914**
Accumulated Depreciation at 1 April 2020	128,469	0	433	38	0	97,226	987	23,285	6,500
Provided during the year	20,924	0	8,935	77	0	9,526	61	1,511	814
Impairments charged to operating expenses	82	0	0	0	0	82	0	0	0
Reversal of impairments credited to operating expenses	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	(837)	0	(837)	0	0	0	0	0	0
Disposals	(8,561)	0	0	0	0	(5,855)	(78)	(1,314)	(1,314)
Depreciation at 31 March 2021	**140,077**	**0**	**8,531**	**115**	**0**	**100,979**	**970**	**23,482**	**6,000**

9.2 Analysis of Property, Plant and Equipment

Net book value									
- Purchased at 31 March 2021	367,455	10,950	283,289	1,577	23,579	40,131	255	3,961	3,713
- Finance Leases at 31 March 2021	569	0	0	0	0	514	0	55	0
- PFI at 31 March 2021	13,246	0	13,246	0	0	0	0	0	0
- Gov't. granted/Donated assets at 31 March 2021	28,184	671	22,867	401	24	4,013	0	7	201
- Donated from DHSC re COVID at 31 March 2021	1,640	0	0	0	0	1,640	0	0	0
Total at 31 March 2021	**411,094**	**11,621**	**319,402**	**1,978**	**23,603**	**46,298**	**255**	**4,023**	**3,914**

9.3 Property, Plant and Equipment 2019/20

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information Technology	Furniture and fittings
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation at 1 April 2019	520,861	11,187	317,904	2,093	13,437	137,282	1,232	26,824	10,902
Additions - purchased	43,475	0	1,620	0	37,279	3,060	63	1,290	163
Additions - leased assets	88	0	0	0	0	0	0	88	0
Additions - donated	646	0	0	0	0	646	0	0	0
Additions - assets purchased from cash donations	367	0	0	0	204	144	0	0	19
Impairments charged to operating expenses	(23,235)	0	(23,188)	0	(44)	0	0	(3)	0
Impairments charged to revaluation reserve	(3,235)	0	(3,235)	0	0	0	0	0	0
Reversal of impairments credited to operating expenses	494	0	494	0	0	0	0	0	0
Reversal of impairments credited to revaluation reserve	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	24,533	0	(28,073)	2,513	0	459	568
Revaluations	(16,134)	0	(16,134)	0	0	0	0	0	0
Disposals	(4,839)	0	0	0	0	(2,762)	(75)	(891)	(1,111)
Cost or valuation at 31 March 2020	**518,488**	**11,187**	**301,994**	**2,093**	**22,803**	**140,883**	**1,220**	**27,767**	**10,541**
Accumulated Depreciation at 1 April 2019	129,643	0	8,652	95	0	90,357	993	22,797	6,749
Provided during the year	20,605	0	8,888	64	0	9,343	69	1,379	862
Impairments recognised in operating expenses	296	0	0	0	0	296	0	0	0
Reversal of impairments credited to operating expenses	(8)	0	0	0	0	(8)	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Other Revaluations	(17,228)	0	(17,107)	(121)	0	0	0	0	0
Disposals	(4,839)	0	0	0	0	(2,762)	(75)	(891)	(1,111)
Depreciation at 31 March 2020	**128,469**	**0**	**433**	**38**	**0**	**97,226**	**987**	**23,285**	**6,500**

9.4 Analysis of Property, Plant and Equipment

Netbook value									
- Purchased at 31 March 2020	359,671	10,516	276,280	1,639	22,760	40,048	233	4,400	3,795
- Finance leases at 31 March 2020	928	0	0	0	0	856	0	72	0
- PFI at 31 March 2020	1,746	0	1,746	0	0	0	0	0	0
- Government granted/Donated assets at 31 March 2020	27,674	671	23,535	416	43	2,753	0	10	246
- Donated from DHSC re COVID at 31 March 2020	0	0	0	0	0	0	0	0	0
Total at 31 March 2020	**390,019**	**11,187**	**301,561**	**2,055**	**22,803**	**43,657**	**233**	**4,482**	**4,041**

9.5 Economic life of property, plant and equipment

	Minimum Life (Years)	Maximum Life (Years)
Land	Infinite	Infinite
Buildings excluding dwellings	18	58
Dwellings	17	34
Plant & Machinery	5	15
Transport Equipment	7	7
Information Technology	5	8
Furniture & Fittings	10	10

9.6 Non-property valuations

Depreciated historical cost is the basis for determining fair value for the Trust's non-property assets. This is not considered to be materially different from fair value.

9.7 Property valuations

Net book value of assets covered by valuation method	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000
Modern Equivalent Asset (no Alternative Site)	0	0	0
Modern Equivalent Asset (Single Site)	11,621	319,402	0
Market value in existing use	0	0	1,978
Fair value (surplus PPE land and buildings)	0	0	0
Total at 31 March 2021	**11,621**	**319,402**	**1,978**

The Trust undertook a full site revaluation of the land and property estate at 31st March 2020 based on a single site valuation model with its expert advisors, Cushman & Wakefield as members of the Royal Institute of Chartered Surveyors, providing an updated valuation estimation which is compliant with RICS standards.

The valuation exercise was carried out in March 2020 with a valuation date of 31st March 2020. In applying the Royal Institute of Chartered Surveyors (RCIS) Valuation Global Standards 2020 ("Red Book"), the valuer declared a ‘material valuation uncertainty’ at the date of the valuation report. This was on the basis of uncertainties in the markets at that time caused by the COVID-19 pandemic. The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. The valuer has confirmed that the conditions which created the "material valuation uncertainty" statement at 31st March 2020 have now been removed.

10. Non-current assets for sale and assets in disposal groups 2020/21

There were no non-current assets for sale and assets in disposal groups in either financial year.

11. Non-current assets investments

The Trust has holdings in the following companies that are commercially developing intellectual property. The Trust's holdings in these companies carry a minimal value (approx. £500k) at the Statement of Financial Position date (31 March 2021 and 31 March 2020). None of the entities are material to the Trust's operations, nor classified as subsidiaries, associates or joint ventures under relevant accounting standards.

Companies in which the Trust owns shares	**Shareholding**
Epaq Systems Ltd	43.59%
Elaros 24/7 Ltd	9.80%
Better Hygiene Ltd (Formerly Wetwash Ltd)	5.00%
Zilico ltd	3.52%
Companies limited by guarantee	
Medipex Ltd	Member
Olympic Legacy Park Ltd	Member

12. Inventories

12.1 Inventories by category

	Sub-note	2020/21 £'000	2019/20 £'000
Drugs		6,119	6,336
Energy		302	315
Other (implantable devices, etc.)		7,692	8,021
Total Inventories	**(1)**	**14,113**	**14,672**

12.2 Inventories recognised in expenses

		2020/21 £'000	2019/20 £'000
Inventories recognised in expenses	**(2)**	335,474	290,504
Write down of inventories recognised as an expense	**(3)**	554	62
Total inventories recognised in expenses		**336,028**	**290,566**

(1) Given the social distancing restrictions brought about by COVID-19 at 31st March 2020, physical stock-counts in most areas were not performed at the year-end date. However, individual areas of significant stock-holding are managed by electronic stock systems (and account for over half of the inventory year end balances). These systems are subject to regular physical reconciliation checks during the year, ensuring robust reliance can be placed on system counts. Stock counts at 31st March 2021 were either from these electronic systems or a COVID-19 secure physical count in all but two minor areas. The Trust held no inventory for Nightingale Hospitals at 31 March 2021 or March 2020.

(2) During the 2020/21 financial year the Trust received £12.0m of personal protective equipment donated by DHSC.

(3) During the 2020/21 financial year, the inventory write down includes sums due to expired stock arising from COVID-19 implications.

13. Receivables

13.1 Trade and other receivables falling due within one year

		2020/21 £'000	2019/20 £'000
Contract receivables - NHS and Other DHSC Bodies		17,050	52,504
Contract receivables - Trade and Non DHSC Bodies		5,793	10,267
Contract assets		0	0
Allowance for impaired receivables	**Note 13.3**	(7,965)	(5,948)
Prepayments		6,116	6,406
Interest receivable		0	28
Public Dividend Capital dividend receivable		791	209
VAT receivable		672	857
Other receivables		248	322
Total falling due within one year		**22,705**	**64,645**

13.2 Trade and other receivables falling due after more than one year

Contract receivables - NHS Injury Scheme		6,512	6,343
Total falling due after more than one year		**6,512**	**6,343**
Total Trade and Other Receivables		**29,217**	**70,988**

13.3 Allowances for credit losses (doubtful debts)

	Total £'000	Contract receivables and Contract assets £'000	All other receivables £'000
At 1 April 2020	5,948	5,948	0
New allowances arising	3,011	3,011	0
Reversals of allowances	(726)	(726)	0
Utilisation of allowances	(268)	(268)	0
Total allowance for credit losses at 31 March 2021	**7,965**	**7,965**	**0**
Loss recognised in expenditure	2,285	2,285	0

13.4 Credit losses and impairment of receivable

The Trust has no material category of receivable which requires generic expected credit losses to be recognised.

Receivables are impaired when there is evidence to indicate that the Trust may not recover, in full, sums due. This can be on the basis of legal advice, insolvency of debtors, or other economic factors. Impaired receivables are written off only when all reasonably possible means of recovery have been exhausted. The nature of the Trust's business generally means that no collateral is held against outstanding receivables.

NHS receivables are considered recoverable because the majority of trade is with DHSC or Clinical Commissioning Groups (CCG's) as commissioners for patient care services.

As CCG's are funded by the Government to purchase NHS patient care services, credit scoring is not considered necessary. Similarly, other receivables with related parties are with other Government bodies, so credit scoring is not considered necessary.

The Trust has considered its exposure to potential credit losses in light of the Covid-19 pandemic and does not consider itself exposed to any significantly greater risk; taking this into consideration, its approach to the impairment of receivables remains largely unaltered. .

Prepayments and accrued income are neither past their due date, nor impaired.

Other trade receivables become due immediately as the Trust does not offer extended credit terms.

14. Current asset investments

	2020/21 £'000	2019/20 £'000
Additions	0	595,000
Disposals	0	(595,000)
Cost or valuation at 31 March	0	0

Current asset investments reflect short-term deposits with the National Loan Fund within the Government Banking Service. No investments have been made during the 2020/21 financial year, given the absence of a positive return.

15. Payables

15.1 Trade and other payables

	2020/21 £'000	2019/20 £'000
Amounts falling due within one year:		
NHS payables	19,851	14,274
Trade payables	23,483	29,755
Trade payables - capital	13,056	9,004
Other payables	10,200	9,584
Accruals	57,977	34,599
Social Security and other taxes	15,388	13,536
Public Dividend Capital payable	0	0
Total current trade and other payables	**139,955**	**110,752**
Amounts falling due after more than one year:		
Total non-current trade and other payables:	0	0
Total non-current trade and other payables	**0**	**0**
Total trade and other payables	**139,955**	**110,752**

15.2 Early retirements and outstanding pension contributions included in payables above

	2020/21 Number	2019/20 Number
- Number of cases involved	0	0
	£'000	£'000
- To buy out the liability for early retirements over 5 years	0	0
Outstanding Pensions Contributions at 31 March	9,790	9,317

16. Borrowings

16.1 Current borrowings

	Sub-note	2020/21 £'000	2019/20 £'000
Capital Loans from the DHSC	(1)	1,465	1,466
Obligations under finance leases		551	531
Obligations under Private Finance Initiative contracts		463	468
Total current borrowings		**2,479**	**2,465**
16.2 Non-current borrowings			
Capital Loans from the DHSC	(1)	16,064	17,509
Obligations under finance leases		387	938
Obligations under Private Finance Initiative contracts		16,165	16,628
Total non-current borrowings		**32,616**	**35,075**
Total borrowings (current and non-current)		**35,095**	**37,540**

(1) On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. This announcement does not affect the DHSC loans above, which are normal course of business loans, rather than interim loans. The long term nature of the loans above therefore does not change.

17. Other liabilities

17.1 Current other liabilities

	2020/21 £'000	2019/20 £'000
Deferred income	20,773	19,539
Total current other liabilities	**20,773**	**19,539**

17.2 Non-current other liabilities

Deferred income	2,724	1,324
Total non-current other liabilities	**2,724**	**1,324**
Total other liabilities (current and non-current)	**23,497**	**20,863**

18. Finance obligations

18.1 Finance lease obligations

	2020/21 £'000	2019/20 £'000
Gross lease liabilities	975	1,553
of which liabilities are due		
- not later than one year;	579	578
- later than one year and not later than five years;	396	975
- later than five years.	0	0
Finance charges allocated to future periods	(37)	(84)
Net lease liabilities	**938**	**1,469**
Ageing of net lease liabilities		
- not later than one year;	551	531
- later than one year and not later than five years;	387	938
- later than five years.	0	0
	938	**1,469**

18.2 Liabilities arising from financing activities

	Total £'000	DHSC Loans £'000	Finance Lease with non-DHSC group counterparty £'000	PFI £'000
Carrying value at 1 April 2020	37,540	18,975	1,469	17,096
Financing cash flows - principal	(2,444)	(1,445)	(531)	(468)
Financing cash flows - interest	(1,961)	(861)	(48)	(1,052)
Additions	0	0	0	0
Interest charge arising in year	1,960	860	48	1,052
Carrying value at 31 March 2021	35,095	17,529	938	16,628

18.3 Private Finance Initiative (PFI) Obligations (on Statement of Financial Position)

	2020/21	2019/20
	£'000	£'000
Gross PFI liabilities	26,619	28,139
of which liabilities are due		
- not later than one year;	1,489	1,520
- later than one year and not later than five years;	6,580	6,505
- later than five years.	18,550	20,114
Finance charges allocated to future periods	(9,991)	(11,043)
Net PFI liabilities	**16,628**	**17,096**
Ageing of PFI liabilities		
- not later than one year;	463	468
- later than one year and not later than five years;	2,874	2,628
- later than five years.	13,291	14,000
	16,628	**17,096**

18.4 Amounts included in operating expenses payable to service concession operator

Operator	2020/21	2019/20
	£'000	£'000
Interest charge	1,052	1,088
Repayment of finance lease liability	468	574
Service element	664	649
Capital lifecycle maintenance	865	629
Contingent rent	844	861
	3,893	**3,801**

18.5 Amounts included in operating expenses in respect of PFI transactions deemed to be in the categories listed below

	2019/20	2018/19
	£'000	£'000
Service element	664	649
Depreciation	37	54
	701	**703**

18.6 Finance charges in respect of PFI transactions

Finance charges in respect of PFI transactions are shown under note 7.2.

18.7 PFI scheme details

Estimated capital value of PFI scheme	£13,246K
Contract start date	December 2004
Contract handover date	March 2007
Length of project (years)	32
Number of years to end of project	15 years, 9 months
Contract end date	December 2036

18.8 The Trust is committed to make the following payments for the total service element for on SoFP PFI service concessions for each of the following periods

	2020/21	2019/20
	£'000	£'000
Hadfield Block:		
- Within one year	673	664
- 2nd to 5th years (inclusive)	2,866	2,828
- Later than 5 years	9,253	10,109
	12,792	**13,601**

18.9 Total future payments committed in respect of PFI

	2019/20	2018/19
	£'000	£'000
Hadfield Block:		
- Within one year	3,946	3,895
- 2nd to 5th years (inclusive)	16,796	16,579
- Later than 5 years	54,167	59,210
	74,909	**79,684**

The PFI scheme is a scheme to design, build, finance and maintain a medical ward block on the Northern General Hospital site (Sir Robert Hadfield Block). The Trust is entitled to provide healthcare services within the facility for the period of the PFI arrangement. .

The contract contains payment mechanisms which provide for deductions in the unitary payment made by the Trust in instances of poor performance and unavailability. These mechanisms have been enacted during the 2018/19 financial year in cash terms, pending contractual resolution.

The unitary charge for the scheme is subject to an annual uplift for future price increases. The operators are responsible for providing a managed maintenance service for the length of the contract, after such time these responsibilities revert to the Trust.

Future unitary charge payments will be uplifted based on actual changes in RPI. In terms of assessing future commitments it is assumed that future indexation will be 2.5% p.a. for all remaining years of the contract.

19. Provisions for liabilities and charges

	Current		Non-Current	
	2020/21	2019/20	2020/21	2019/20
Pensions relating to former staff	222	218	3,141	3,087
Legal claims	515	358	178	40
Agenda For Change	0	0	0	0
2019/20 Clinicians' Pension Reimbursement	0	0	181	0
Other	5,008	2,398	485	0
	5,745	**2,974**	**3,985**	**3,127**

	2020/21						2019/20
	Total	**Pensions relating to former staff**	**Legal claims**	**Agenda for Change**	**2019/20 Clinicians' Pension Reimbursement**	**Other**	**Total**
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
At 1 April	6,101	3,305	398	0	0	2,398	5,958
Change in discount rate	144	144	0	0	0	0	239
Arising during the year	4,334	164	847	0	181	3,142	1,129
Utilised during the year	(311)	(216)	(94)	0	0	(1)	(870)
Reversed unused	(506)	(2)	(458)	0	0	(46)	(339)
Unwinding of discount	(32)	(32)	0	0	0	0	(16)
At 31 March	**9,730**	**3,363**	**693**	**0**	**181**	**5,493**	6,101
Expected timing of cashflows							
Within one year	5,745	222	515	0	0	5,008	2,974
Between one and five years	1,750	906	178	0	181	485	923
After five years	2,235	2,235	0	0	0	0	2,204
	9,730	**3,363**	**693**	**0**	**181**	**5,493**	6,101

Pensions relating to former staff represents the liability relating to staff retiring before April 95 (£485k) and Injury Benefit Liabilities (£2,878k). Injury Benefits are payable to current and former members of staff who have suffered injury at work. These cases have been adjudicated by the NHS Pensions Authority. The value shown is the discounted present value of payments due to the individuals for the term indicated by Government Actuary life expectancy tables, and the actual value of this figure represents the main uncertainty in the amounts shown. Legal claims relate to:

- Claims brought against the Trust for Employers Liability or Public Liability. These cases are handled by NHS Resolution who provide an estimate of the Trust's probable liability.
- Actual costs incurred are subject to the outcome of legal action. Costs in excess of £10,000 per case are covered by NHS Resolution and not included above. The provision for such cases totals £277k.
- A number of other legal cases, not being handled by the NHS Resolution, are also recorded under this heading. These total £416k.
- Other Provisions
- The Trust has recognised a provision of £2,659k in respect of potential future pension liabilities which will be charged by the NHS Pensions Agency in respect of final pay controls.
- The Trust has recognised in-year a provision of £1,523k in respect of sundry employment related issues.
- The Trust has recognised a provision of £1,311k in respect of taxation matters which may become payable to HMRC
- £390,221k is included in the provisions of NHS Resolution at 31/03/2021 in respect of clinical negligence liabilities of the Trust (31/3/2020 £354,648k).

20. Revaluation Reserve

	Total Revaluation Reserve £'000	Revaluation Reserve - intangibles £'000	Revaluation Reserve - property, plant and equipment £'000
Revaluation reserve at 1 April 2020	35,179	0	35,179
Transfer by absorption	0	0	0
Impairments	193	0	193
Revaluations	3,113	0	3,113
Transfers to other reserves	(1,046)	0	(1,046)
Other recognised gains and losses	0	0	0
Revaluation reserve at 31 March 2021	**37,439**	**0**	**37,439**
Revaluation reserve at 1 April 2019	38,370	0	38,370
Transfer by absorption	0	0	0
Impairments	(3,235)	0	(3,235)
Revaluations	1,094	0	1,094
Transfers to other reserves	(1,050)	0	(1,050)
Other recognised gains and losses	0	0	0
Revaluation reserve at 31 March 2020	**35,179**	**0**	**35,179**

21. Cash and cash equivalent

	2020/21 £'000	2019/20 £'000
At 1 April	90,775	94,033
Net change in year	95,478	(3,258)
At 31 March	**186,253**	**90,775**
Analysed as cash held:		
- At Commercial Banks and in hand	128	121
- At Government Banking Service	186,125	90,654
Cash and cash equivalents as in the Statement of Financial Position	**186,253**	**90,775**

22. Capital commitments

Commitments under capital expenditure contracts at the Statement of Financial Position Date were £7.6m (31 March 2020, £17.6m).

The major components of these commitments are as follows:	**Property, Plant & Equipment 2020/21** £'000
Scheme:	
Theatre Refurbishment - A Floor, Royal Hallamshire Hospital	1,196
Community Dental Facilities	1,267
Theatre Refurbishment - Firth Wing, Northern General Hospital	506
Lift Refurbishment - Royal Hallamshire Hospital	580
Other	4,032
Total	**7,581**

The reduction in Capital Commitments of £10.0m between financial year ends is mainly driven by Trust capital planning and business case approval timings. There is no significant effect from the impact of COVID-19 on the placement of Trust contractual commitments.

23. Events after the reporting period

There are no other events after the reporting period to highlight.

24. Contingencies

24.1 Contingent liabilities

	2020/21 £'000	**2019/20** £'000
Gross value	(130)	(189)
Amounts recoverable	0	0
Net contingent liability	(130)	(189)

Quantified contingencies shown above represent the consequences of losing all current third party legal claim cases currently with NHS Resolution and represent the Trust's excess is relation to such cases, however, the likelihood of losing all cases is considered remote. Note 19 quantifies those cases which have been provided for (£693k) where it is considered more likely that liabilities will crystallize.

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24.2 Contingent assets

The Trust is currently involved in an ongoing contractual dispute which may result in future economic benefits relating to past events. Income has been recognised in the financial statements only when it meets the criteria detailed in the Department Of Health and Social Care Group Accounting Manual. The ongoing dispute may result in additional future economic benefits, however these have not been recognised in the financial statements due to uncertainty around the amount of these economic benefits, given the present status of the contractual dispute. .

25. Related party transactions

Sheffield Teaching Hospitals NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Sheffield Teaching Hospitals NHS Foundation Trust. Details of Directors' remuneration and pension benefits can be found in the Remuneration Report in the Annual Report. The Declaration of Directors' interests is to be found on page 32 of the Annual Report.

The Department of Health and Social Care is regarded as a related party. During the year Sheffield Teaching Hospitals NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department including NHSE, Health Education England and NHS Resolution.

In addition, the Trust has had a number of material transactions with other joint enterprises, government departments and other central and local government bodies. Most of these transactions have been with the Department of Education in respect of The University of Sheffield, and with Sheffield City Council in respect of joint enterprises. Income from the University of Sheffield and Sheffield City Council totalled £3,892k and £4,239k respectively.

Expenditure on goods and services was in the sum of £14,396k from the University of Sheffield and £5,920k from Sheffield City Council. At 31 March 2021 £4,120k was owed to the Trust by the University of Sheffield, whilst £6,380k was owed.

The Trust considers other NHS Foundation Trusts and NHS bodies to be related parties, as they and the Trust are under the common control of Monitor (NHS Improvement from 1 April 2016), and the Department of Health and Social Care. During the year the Trust contracted with certain other Foundation Trusts and Trusts for the provision of clinical and non-clinical support services. Those organisations where the value exceeded £20m include Barnsley CCG, Derby & Derbyshire CCG, Rotherham CCG and Sheffield CCG.

Some other entities with whom the Trust trades are considered related parties. These entities are to an extent controlled and / or influenced by certain Non-Executive Directors by the nature of their engagement with that body. Mr Tony Pedder, during his period of tenure as Chairman, was Pro-Chancellor and Chair of Council, University of Sheffield. Mr Chris Newman, Non-Executive Director, is Dean of the Medical School, University of Sheffield. As mentioned in the Directors' Report, a full Register of Directors' Interests is maintained by the Assistant Chief Executive.

During the year the Trust purchased healthcare from Thornbury Private Hospital in the sum of £455k whilst spend with Claremont Hospital was negligible. Certain of the Trust's clinical employees have an interest in these companies. Clinical services were provided to these organisations.

Certain members of the Trust's Governors' Council are appointed from key organisations with which the Trust works closely. These governors represent the views of the staff and of the organisations with and for whom they work. This representation on the Governors' Council gives important perspectives from these key organisations on the running of the Trust, and is not considered to give rise to any potential conflicts of interest.

The Trust is a significant recipient of funds from Sheffield Hospitals Charity of whom Mr John O'Kane, Non-Executive director, is a trustee. Grants received in the year from this Charity amounted to £1.2m (2019/20 £2.3m).

26. Financial instruments

26.1 Financial assets

Carrying values of financial assets as at 31 March 2021 under IFRS 9	Held at amortised cost	Held at fair value through P&L	Held at fair value through OCI	Total
	£'000	£'000	£'000	£'000
Receivables excluding non-financial assets	21,638	0	0	21,638
Other investments / financial assets	0	0	0	0
Cash and cash equivalents at bank and in hand (at 31 March 2021)	186,253	0	0	186,253
Total at 31 March 2021	**207,891**	**0**	**0**	**207,891**

Carrying values of financial assets as at 31 March 2020 under IFRS 9	Held at amortised cost	Held at fair value through P&L	Held at fair value through OCI	Total
	£'000	£'000	£'000	£'000
Receivables excluding non-financial assets	63,516	0	0	63,516
Other investments / financial assets	0	0	0	0
Cash and cash equivalents at bank and in hand (at 31 March 2020)	90,775	0	0	90,775
Total at 31 March 2020	**154,291**	**0**	**0**	**154,291**

26.2 Financial liabilities by category

Carrying values of financial liabilities as at 31 March 2021 under IFRS 9	Held at amortised cost	Liabilities at fair value through the SoCI	Total
	£'000	£'000	£'000
Borrowings excluding Finance lease and PFI liabilities	17,529		17,529
Finance lease obligations	938		938
Obligations under Private Finance Initiative contracts	16,628		16,628
Trade and other payables excluding non-financial assets	114,367		114,367
Provisions under contract	0		0
Total at 31 March 2021	**149,462**	**0**	**149,462**

Carrying values of financial liabilities as at 31 March 2020 under IFRS 9	Held at amortised cost	Liabilities at fair value through the SoCI	Total
	£'000	£'000	£'000
Borrowings excluding Finance lease and PFI liabilities	18,975		18,975
Finance lease obligations	1,469		1,469
Obligations under Private Finance Initiative contracts	17,096		17,096
Trade and other payables excluding non-financial assets	87,632		87,632
Provisions under contract	0		0
Total at 31 March 2021	**125,172**	**0**	**125,172**

26.3 Maturity of financial liabilities	2020/21	2019/20 As restated*
	£'000	£'000
In one year or less	118,695	92,057
In more than one year but not more than five years	15,527	16,041
In more than five years	30,474	34,268
Total	**164,696**	**142,366**

* Comparative values have been restated to reflect IFRS7 which requires the liabilities to be based on undiscounted future contractual cash flows, rather than on book values.

26.4 Fair values of financial assets and liabilities at 21 March 2021

Financial risk management

Financial reporting standard IFRS7 requires disclosure of the role that financial instruments have had during the period in creating and changing the risks a body faces in undertaking its activities. Due to the continuing service provider relationship that the Trust has with Clinical Commissioning Groups (CCG's), and the way the DHSC/CCG's are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's Treasury Management operations are carried out by the Finance Department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust has borrowings for capital expenditure, but is subject to affordability as confirmed by the FT Financing Facility. The borrowings are for a maximum remaining period of sixteen years and nine months (16 years, 9 months), in line with the associated assets, and interest is charged at 4.80% and 4.59%, fixed for the life of the respective loans. The Trust therefore has low exposure to interest rate fluctuations in this area. The Trust also has borrowings in respect of leasing and its PFI contract which incur fixed interest rates of 4.00% and 6.32% respectively. Exposure to interest rate risk is therefore low as these borrowings are fixed.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2021 are in receivables from customers, as disclosed in the Trade and other receivables note. Owing to the architecture of its financial regime, the Trust does not consider itself to be exposed to any significant greater credit risk as a result of the Covid-19 pandemic.

Liquidity risk

The Trust's operating costs are largely incurred under contracts with Clinical Commissioning Groups, or the Department of Health and Social Care, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its internally generated resources. The Trust is not, therefore, exposed to significant liquidity risks. As with credit risk, the Trust does not consider itself to be exposed to any significant greater liquidity risk as a result of the Covid-19 pandemic.

27. Third party assets

The Trust held £20k at bank and in hand at 31 March 2021 (£2k at 31 March 2020), which related to monies held on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts (see note 21).

28. Losses and special payments

	2020/21		2019/20	
	Number	Value £'000	Number	Value £'000
Losses				
Cash Losses	1	0	3	0
Fruitless payments and constructive losses	0	0	1	0
Bad debts and claims abandoned	320	266	84	24
Stores losses (including damage to buildings and property)	10	557	4	68
	331	**823**	**92**	**92**
Special payments				
Extra-contractual payments	0	0	0	0
Extra-statutory and extra-regulatory payments	0	0	0	0
Compensation payments	2	29	1	3
Special severance payments	0	0	0	0
Ex-gratia payments	44	16	68	13
	46	**45**	**69**	**16**
Total losses and special payments	**377**	**868**	**161**	**108**

No individual items exceeding £300,000 were incurred in either year. These losses are reported on an accruals basis.

29. Public Dividend Capital Dividend

The Trust is required to absorb the cost of capital at a rate of 3.5% of average net relevant assets, and to pay a dividend based on this rate to HM Treasury. The rate of 3.5% is applied to the Trust's net relevant assets, which are abated by the value of donated assets, the value of PDC received for COVID-19 assets, any dividend payable or receivable (where appropriate), and by average daily cleared balances held with the Government Banking Service. This resulted in a dividend of £5,666k (2019/20 £8,032k).

For more information please contact:

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